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

March 30, 2026

GARVEY MANOR NURSING HOME

RE: OUR LADY OF THE ALLEGHENIES RESIDENCE
1037 SOUTH LOGAN BOULEVARD
HOLLIDAYSBURG, PA, 16648
LICENSE/COC#: 31641

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/03/2026 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: *OUR LADY OF THE ALLEGHENIES RESIDENCE* **License #**: *31641* **License Expiration**: *08/29/2026*

Address: *1037 SOUTH LOGAN BOULEVARD, HOLLIDAYSBURG, PA 16648*

County: *BLAIR* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *GARVEY MANOR NURSING HOME*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *06/09/2023* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/03/2026*

Inspection Dates and Department Representative

03/03/2026 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *28*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

03/03/2026 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/21/2026*

Inspections / Reviews *(continued)*

03/17/2026 POC Submission

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

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

03/30/2026 Document Submission

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

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On at 10:45 PM, the fire sprinkler system discharged unexpectedly in bedroom The room suffered water damage including to the floor, ceiling tiles, and the heating unit. The occupant of the room was relocated to another room while the room remains vacant until repairs are completed. This incident was not reported to the Department.

Plan of Correction ***Accept - 03/17/2026)***

Upon identification of the oversight and final inspection report received on 3/12/26, the Designee, immediately re-reviewed the incident that occurred on 12/10/25, and a report was submitted to the DHS via email reporting requirements to ra-pwarlcentral@pa.gov on 3/12/26.

Upon review of the incident that occurred on 12/10/25, it was determined that water damage in room 106 resulted from a pipe/coupler failure within the building's sprinkler system and not from the activation of a sprinkler head due to fire conditions. The resident occupying the room was safely relocated and the room remains vacant while repairs are completed.

At the time of the incident, the event was addressed internally, and appropriate maintenance repairs were initiated; however, the incident was not reported to the Department.

Plan of Correction: The Administrator and designee have reviewed incident reporting requirements to ensure that any future environmental incidents, including water damage events involving building systems such as sprinkler lines, will be reported to the Department within 24 hours in accordance with reporting requirements 55 Pa. Code § 2600.16.

The Administrator and designee have also reviewed the incident reporting policy and procedures to ensure clarity regarding reportable incidents. Administrative staff responsible for incident reporting have been re-educated on the requirement to report environmental incidents such as sprinkler discharges to the Department within 24 hours.

Using the facilities Quality Assurance and Improvement Plan, the Administrator or designee will monitor incident reports to ensure compliance with reporting requirements on a quarterly basis. These reports will be documented, reviewed, and recorded at the quarterly QA meetings.

Responsible Party
Administrator / Designee
Completion Date
03/12/2026

Licensee's Proposed Overall Completion Date: *03/16/2026*

Implemented - 03/30/2026)

132c - Fire Drill Records

2. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home is not accurately recording the number of residents present in the home at the time of fire drills and instead is using census information which includes residents not physically present.

The fire drill record for the drill conducted on at 11:00 AM states there were 28 residents present and 11 evacuated. Additional supplemental documentation the home provided indicates that there were 15 residents present and 15 evacuated.

During the fire drill conducted on at 11:27 PM, there were 27 residents present and 27 evacuated, however, the fire drill record states there were 16 residents present and 29 evacuated. In addition, this drill does not include seconds, only the amount of minutes it took to evacuate the residents.

During the fire drill conducted on at 10:45 PM, there were 30 residents present and 25 evacuated, however, the fire drill record states there were 13 residents present and 30 evacuated. There is no documentation of any problems during this drill including why 5 residents did not evacuate.

During the fire drill conducted on at 1:00 PM, there were 21 residents present in the home, however, the fire drill record states there were either 29 residents evacuated or 22 if referring to supplemental documentation the home completes.

The drill conducted on at 7:15 AM does not include the amount of time required to evacuate the residents including minutes and seconds.

Plan of Correction

Accept - 03/17/2026)

The facility staff responsible for completing fire drill records and administration immediately reviewed recent fire drill documentation to ensure accuracy and completeness. Education and guidance was provided to staff by to Maintenance Director and Assistant Director of Maintenance on the proper documentation of fire drills.

Initiated 3/12/26 the facility will now record fire drills on the ARL PCH Fire Drill Record recommended form 55 Pa. Code § 2600.132(c) and will ensure that future fire drills are conducted and documented in accordance with 55 Pa. Code § 2600.132.

Plan of Correction
The fire drill documentation process was reviewed with staff responsible for completing fire drill records to ensure all required elements are accurately recorded including: actual number of residents present in the home.

- *number of residents evacuated*
- *staff participating*
- *exit route used*
- *evacuation time including minutes and seconds*
- *problems encountered*

132c - Fire Drill Records (continued)

The fire drill documentation form has been reviewed with staff to ensure census information reflects only residents physically present in the home at the time of the drill.

Staff responsible for conducting and documenting drills have been re-educated on proper documentation requirements.

The Administrator or designee will review fire drill documentation after each drill to ensure accuracy, compliance, and completeness. Any concerns, errors, or discrepancies discovered will be addressed immediately after each drill.

Using the facilities Quality Assurance and Improvement Plan, the Administrator or designee will document these reviews at the quarterly QA meetings.

Responsible Party
Administrator / Maintenance Director / Designee
Completion Date
03/21/2026

Licensee's Proposed Overall Completion Date: *03/21/2026*

Implemented - 03/30/2026)

132h - Designated Meeting Place

3. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on at 10:45 PM, 5 residents did not evacuate to a designated meeting place away from the building or within fire-safe areas including beyond fire doors or in the stairwells.

Plan of Correction ***Accept - 03/17/2026)***

Education, technical assistance, and guidance were provided by to Maintenance Director and Assistant Director of Maintenance to clarify the proper documentation and procedure of residents evacuated to the designated meeting place.

Administrator, Designee, and maintenance staff were re-educated on the requirement that residents participating in fire drills must evacuate to a designated meeting place away from the building or within a fire-safe area, including beyond fire doors or stairwells when appropriate.

POC: During future drills, staff will ensure that all residents evacuate to the designated meeting location unless there is a documented safety concern.

Fire drill procedures have been reviewed with staff to reinforce evacuation expectations.

The Administrator or designee will monitor future fire drills to ensure compliance. Using the facilities Quality Assurance and Improvement Plan, the Administrator or designee will document these reviews at the quarterly QA

132h Designated Meeting Place (continued)

meetings.

Responsible Party
Administrator [redacted] / Maintenance Director [redacted] / Designee [redacted]
Completion Date
03/21/2026

Licensee's Proposed Overall Completion Date: *03/21/2026*

Implemented [redacted] 03/30/2026)

185a - Implement Storage Procedures

4. 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 [redacted] [redacted] is incorrectly dated and timed and when turned on, read [redacted] at 4:33 PM when it was actually [redacted] at 11:05 AM. In addition, the following readings stored on the meter don't match those recorded on the resident's medication administration record (MAR) including:
on [redacted] at 1:42, a blood sugar of [redacted] was recorded on the MAR as [redacted]
on [redacted] at 1:31, a blood sugar of [redacted] was not recorded on the resident's MAR

Resident [redacted]s glucometer was incorrectly dated and timed and on [redacted] at 11:33 AM displayed the date of [redacted] at 1:07 PM.

Plan of Correction ***Accept [redacted] - 03/17/2026)***

Upon discovery, both glucometers were corrected immediately to reflect the correct date and time. Resident [redacted] glucometer corrected by staff PCA [redacted] Resident [redacted] glucometer was corrected by staff member [redacted] LPN, Resident Services Coordinator.

Resident # [redacted] blood glucose readings were reviewed and documentation was corrected as appropriate. Staff were re educated on the importance of ensuring glucometers reflect the correct date and time and that readings recorded on the glucometer match the documentation recorded on the Medication Administration Record (MAR).

Plan of Correction: Medication administration staff have been instructed to verify the date and time on glucometers during use and to ensure accurate documentation of readings.

The Resident Service Coordinator has developed a digital ongoing monitoring evaluation to maintain Glucometers date, time and readings stored in the machine to maintain compliance. Audits will be completed weekly x 14 weeks and then going on a Monthly Check to maintain compliance.
Using the facilities Quality Assurance and Improvement Plan. These reports will be documented, reviewed, and recorded at the quarterly QA meetings.

Responsible Party
Administrator [redacted] / LPN/Resident Service Coordinator [redacted] / Medication Administration Staff

185a Implement Storage Procedures (continued)

Completion Date
03/12/2026

Licensee's Proposed Overall Completion Date: *03/16/2026*

Implemented - 03/30/2026)

227d - Support Plan Medical/Dental

5. 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

The support plan for Resident completed , does not include risks associated with the use of bedside mobility device and the need for a cover for the device.

Plan of Correction ***Accept - 03/17/2026)***

Resident s support plan was reviewed and updated on 3/12/26 to include risks associated with the resident's bedside mobility device, the need for the device, and the need for the appropriate covering by LPN, Resident Services Coordinator. Resident Services Coordinator reviewed the RASP with resident and recorded resident signature as provided.

Administrator and REsident Services Coordinator were educated on ensuring that all required documentation required be present on a support plan when a resident has an assistive device. Documentation requirements and handouts provided by surveyor including:
the specific need for the device
intended use and risks of the device
the ability of the resident to safely use the device
identification of the specific device to be used and whether a cover is necessary to meet FDA guidelines

Support plans will be reviewed to ensure that all necessary medical and safety considerations are included as identified.

Using the facilities Quality Assurance and Improvement Plan, The Administrator or designee will review support plans every quarter to ensure compliance with documentation requirements. These reports will be documented, reviewed, and recorded at the quarterly QA meetings.

Responsible Party
Administrator / Resident Services Coordinator
Completion Date
03/12/2026

Licensee's Proposed Overall Completion Date: *03/16/2026*

227d - Support Plan Medical/Dental *(continued)*

Implemented (- 03/30/2026)