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

June 10, 2026

, BOARD PRESIDENT
SUGAR VALLEY LODGE INC

RE: SUGAR VALLEY LODGE (POLK)
196 CHURCH STREET
POLK, PA, 16342
LICENSE/COC#: 44549

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/10/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SUGAR VALLEY LODGE (POLK)* **License #**: *44549* **License Expiration**: *04/24/2026*

Address: *196 CHURCH STREET, POLK, PA 16342*

County: *VENANGO* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *SUGAR VALLEY LODGE INC*

Address: *196 SUGAR VALLEY LANE, FRANKLIN, PA, 16323*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/1992* **Issued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *12* **Waking Staff**: *9*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/10/2026*

Inspection Dates and Department Representative

03/10/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *15* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10* **Are 60 Years of Age or Older**: *9*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *6*

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

Inspections / Reviews

03/10/2026 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/29/2026*

03/27/2026 - POC Submission

Submitted By: **Date Submitted**: *05/06/2026*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/03/2026*

Inspections / Reviews *(continued)*

04/22/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/06/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/15/2026*

06/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/06/2026*

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

20b6 - Interest Bearing Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
6. If a home is holding more than $200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

Description of Violation

The home held money for resident #1, who has held a balance since beyond 1/1/26 that has exceeded a balance of $200. However, the resident was not offered assistance in establishing an interest-bearing account in the resident's name at a local federally insured financial institution.

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO identified that the residents listed do not have the correct paperwork stating that the interest bearing account was offered.
On 3/11/26 COO worked with Financial Manager to correct this error, including any resident that has over $200 in their account.
By 3/11/26, COO has the signed documentation to show interest bearing accounts were offered to those with over $200 in their account. Every month, starting 4/2026, COO and finance manager will audit residents checking account balances so that if they are close to $200 we offer an interest bearing account.

Licensee's Proposed Overall Completion Date: *04/02/2026*

Implemented (- 06/10/2026)

20b8 - Quarterly Account

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Multiple residents, including resident #1 and resident #2, did not receive any quarterly statements in the 2025 year.

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO identified that the quarterly reports were not up to date for the current year for multiple residents
On 3/11/26 COO and Financial Manager are working on getting these up to date.
By 5/3/26, Financial Manager will have the current quarterly reports for 2026 ready for each resident. Every quarter, COO and CEO will audit resident charts to make sure they comply with having quarterly reports.

Licensee's Proposed Overall Completion Date: *05/03/2026*

Implemented (- 06/10/2026)

65f Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person A, hired on [redacted], did not receive annual training in training year 2025 in the following areas:
Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
Personal care service needs of the resident
Safe management techniques
REPEAT VIOLATION: 3/11/25

Plan of Correction ***Accept ([redacted] - 04/08/2026)***

On 3/10/26 [redacted] COO identified that we did not have all the training sign in sheets for this individual at the Polk location.
By 3/11/26 [redacted] COO found said sign in sheet showing the training for said staff person. This is attached.
By 4/2/2026 [redacted] COO and [redacted] CEO will have trainings documented on an audit sheet. Every 3 months we will audit training logs. At the end of each year, [redacted] COO and [redacted] CEO will have the staff sign in sheets for the prior year at both locations, Sugarcreek and Polk.

Licensee's Proposed Overall Completion Date: *04/02/2026*

Implemented ([redacted] - 06/10/2026)

65g Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person A, hired on [redacted] did not receive training on the topic Falls and accident prevention in the training year 2025.
REPEAT VIOLATION: 3/11/25

Plan of Correction ***Accept ([redacted] - 04/08/2026)***

On 3/10/26 [redacted] COO did not have the training sheet showing Fall Prevention for staff person A..
3/12/26-Upon going through the training logs for 2025, [redacted] COO did find the training log in sheet for Staff Person A.
By 3/23/26 [redacted] COO uploaded the document showing the training sign in sheet with the staff persons signature. Every 3 months staff charts will be audited for training updates by [redacted] COO and [redacted] CEO.

Licensee's Proposed Overall Completion Date: *04/02/2026*

65g - Annual Training Content *(continued)*

Implemented (- 06/10/2026)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 9:59 a.m., there was an uncovered garbage can, ¼ full with candy wrappers, tissues, and Styrofoam cups, near the seating area immediately inside the main entrance to the home.

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO identified that the garbage can in the main hallway had trash in it with no lid.
On 3/10/26, COO pulled said garbage can so that until it has a lid will be put back for residents to use.
By 3/23/26, COO went through the building and any garbage can that is outside a resident room, without a lid is pulled and no longer in use until we have lids for them. The trash can identified in the violation was not in a kitchen or a bathroom. CEO and COO are going to add trash can checks for lids and making sure they are emptied to the Quality Checks each month.

Licensee's Proposed Overall Completion Date: *04/02/2026*

Implemented (- 06/10/2026)

85e - Trash Outside Home

6. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 9:56 a.m., there was no lid covering the dumpster that was approximately ½ full of garbage.

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO, identified that the dumpster lid was open.
On 3/10/26 COO posted in the group chat that the dumpster lid is to be closed At all times.
By 3/23/26, COO Trained staff on closing the dumpster lid and will continue to monitor the dumpster to make sure the lid is closed at all times. This will be added to the Quality Checks each week to make sure the lid to the dumpster is closed.

Licensee's Proposed Overall Completion Date: *04/02/2026*

Implemented (- 06/10/2026)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a - Unobstructed Egress *(continued)*

Description of Violation

At approximately 9:54 a.m., 2 green plastic chairs were blocking both emergency exit doors leading from the unlocked boiler room to the exterior of the home.

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO identified that the chairs outside the back doors leading outside were blocking a fire exit.
On 3/11/26, COO removed the chairs from Infront of the doors.
By 4/15/26 COO will have instructed staff that nothing should be placed in front of any fire exits and checking fire exits month will be added to the Monthly Quality checks.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented (- 06/10/2026)

130g - Smoke Detector Repair

8. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

At approximately 10:00 a.m., the Fire panel's display located in the Home's front lobby indicated "Trouble in system Comm Fault 1".

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO identified the communication error on the fire alarm panel.
On 3/10/26 COO contacted the Fire Fighter Company, asking them to fix the trouble in system Comm Fault error.
On 3/10/26 COO problem solved with the service and it was required to have a repair man come to fix the issue in the am. Staff completed a "Fire Walk" every 15 minutes until the company arrived on 3/11/26 to fixe the Communication Error. The invoice is attached to the plan of correction/violation.
By 4/15/26 COO will have Ashley Crawford, Medical Assistant add daily inspections of the fire panel to our staff daily check sheet to make sure the system is running as it should.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented (- 06/10/2026)

227d - Support Plan Medical/Dental

9. 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 #1 had 2 half-rails on each side of bed. The support plan, dated did not address the intended use and any risks associated with the use, the resident ability to use the device safely for the purpose it was intended, and

227d - Support Plan Medical/Dental (continued)

identification of the specific device to be used and whether a cover is required to meet the FDA guidelines.
REPEAT VIOLATION: 3/11/25

Plan of Correction ***Accept (- 04/08/2026)***

On 3/10/26 COO identified that Resident #1 did not have the bed rails listed on the Support Plan.
On 3/11/26 COO created an update form to include the bed rails on the support plan for 4/2026.
By 4/20/26, COO and Med Asst. will update the annual review of the RASP to include the bed rails,
By 4/30/26 COO and CEO will update the Policy and Procedure Manual to include the new policy on bed rails.
On 5/1/26 CEO and COO will hold a staff training on bed rails and the new Policy . We will also have form for a Dr/ PA to fill out for each resident that has bed rails. This form will include the intended use and any risks associated with the bed rails, the resident ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 06/10/2026)