

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

July 1, 2026

[REDACTED], ADMINISTRATOR
SNH PENN TENANT LLC

RE: CLARKS SUMMIT SENIOR LIVING
950 MORGAN HIGHWAY
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22821

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/12/2026, 03/17/2026 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: CLARKS SUMMIT SENIOR LIVING License #: 22821 License Expiration: 01/01/2027
 Address: 950 MORGAN HIGHWAY, CLARKS SUMMIT, PA 18411
 County: LACKAWANNA Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: SNH PENN TENANT LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 12/22/1999 Issued By: L & I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 102 Waking Staff: 77

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 03/17/2026

Inspection Dates and Department Representative

03/12/2026 - On-Site: [REDACTED]
 03/17/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 120 Residents Served: 91

Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:

Hospice
 Current Residents: 5

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 91
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 11 Have Physical Disability: 0

Inspections / Reviews

03/12/2026 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/11/2026

06/11/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 06/16/2026
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 06/16/2026

Inspections / Reviews *(continued)*

07/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/16/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [REDACTED] and their Criminal History background check was not initiated until 3/12/26

Plan of Correction

Directed ([REDACTED] - 06/10/2026)

- The BOM (Business Office Manager) audited all employee files for criminal history checks on 3/18/2026 to ensure compliance with regulation 51. SEE ATTACHED
- Effective immediately, no team member will be put on the schedule until a criminal history check is obtained and in compliance with regulation 51.
- Starting 4/1/2026, the BOM or designee will audit all new hire files monthly for 3 months then quarterly for 2 quarters to ensure compliance with regulation 51. SEE ATTACHED

Proposed Overall Completion Date: 04/10/2026

Directed: In addition to the above plan of correction, all staff that complete criminal background checks for new hires will be educated in the requirements of criminal background checks in personal care homes.

Directed Completion Date: 06/16/2026

Implemented ([REDACTED] - 06/17/2026)

65f - Training Topics

2. Requirements

2600.

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

1. Medication self-administration training.

Description of Violation

Direct Care Staff Person B did not receive training in Medication Self-Administration during the 2025 training year.

Plan of Correction

Directed ([REDACTED] - 06/10/2026)

- An audit of the 2025 annual training for direct care staff persons was completed by ED (Executive Director) on 3/13/2026 to ensure compliance with regulation 65f.
- Direct Care Staff Person B did complete the Medication self-administration training on 3/12/2026 (SEE ATTACHED)
- Starting 4/1/2026, the ED or designee will review annual trainings monthly for 6 months to ensure compliance with regulation 65f. (SEE ATTACHED)

Proposed Overall Completion Date: 04/10/2026

Directed: In addition to the above plan of correction, the ED or designee will schedule a makeup training for any staff person that is identified during the monthly training review as having missed the training. All make up trainings will be completed that calendar year to ensure regulation compliance.

Directed Completion Date: 06/16/2026

Implemented ([REDACTED] - 06/17/2026)

65f Training Topics (continued)

141a - Medical Evaluation

3. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident 1’s admission date was [REDACTED] and their medical evaluation was completed on [REDACTED]. The medical evaluation was not completed within 60 days prior to admission.

Plan of Correction

Accept ([REDACTED] - 06/11/2026)

- On 4/2/2026, the DHW (Director of Health and Wellness) completed audit of all resident DME’s to ensure compliance with regulation 141a.
- DHW, ADHW (Assistant Director of Health and Wellness), and LPN (Licensed Practical Nurse) were educated by ED on 4/7/2026 on regulation 141a to ensure ongoing compliance with regulation 141. (SEE ATTACHED)
- Beginning 4/1/2026, DHW, ADHW or Designee will audit 2 DME’s a week for 3 months and then 2 DME’s bi monthly for 3 months to ensure ongoing compliance with regulation 141a. (SEE ATTACHED)

Licensee’s Proposed Overall Completion Date: 06/16/2026

Implemented ([REDACTED] - 06/17/2026)

141a 1-10 Medical Evaluation Information

4. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident 2’s initial medical evaluation was incomplete and does not have a date when the medical evaluation was completed by a medical professional.

Plan of Correction

Directed ([REDACTED] - 06/10/2026)

- On 4/2/2026, the DHW completed audit of all resident DME’s to ensure compliance to regulation 141.

141a 1-10 Medical Evaluation Information (continued)

- DHW, ADHW, and LPN were educated by Executive Director on 4/7/2026 on regulation 141a to ensure ongoing compliance with regulation 141. (SEE ATTACHED)
- Beginning 4/1/2026, the DHW, ADHW or Designee will audit 2 DME's a week for 3 months and then 2 DME's bi-monthly for 3 months to ensure ongoing compliance with regulation 141a. (SEE ATTACHED)

Proposed Overall Completion Date: 04/10/2026

Directed: In addition to the above plan of correction, a completed DME with date of evaluation for Resident #2 will be obtained and kept in the resident record.

Directed Completion Date: 06/16/2026

Implemented (█) - 06/17/2026)

144c1 - Smoking Area Guidelines

5. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

Description of Violation

At 10:01 a.m. on 3/12/26, the designated smoking area located near the main entrance of the home was observed to have two cigars discarded on the grass approximately seven feet from the home's 4-gallon Smokers Cease-Fire cigarette receptacle.

Repeat Violation: 2/27/2025

Plan of Correction

Directed (█) - 06/10/2026)

- On 3/12/2026, the two cigars were immediately disposed of upon discovery on day of inspection by Facilities Director.
- On 4/9/2026, a letter was sent to residents, families and team members reviewing the community's smoking policy and the requirements to be in compliance with regulation 144c. (SEE ATTACHED)
- Starting the week of 3/23/2026, Facilities director or designee will monitor community grounds twice a week for 2 months, then weekly for 2 months then biweekly for 2 months to ensure compliance with regulation 144c. (SEE ATTACHED)

Proposed Overall Completion Date: 04/10/2026

Directed: In addition to the above plan of correction, any staff or resident found breaking the home's smoking policy will be educated and informed of possible consequences for repeated offenses.

Directed Completion Date: 06/16/2026

Implemented (█) - 06/17/2026)

181c - Self-administration Assessment

6. Requirements

2600.

181c - Self-administration Assessment (continued)

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 3 self-administers medications to include Tums Antacid; however, Resident 3 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and their need for reminders to take medications.

Plan of Correction**Accept (█ - 06/11/2026)**

- *On 3/17/2026, the bottle of tums was removed from resident 3's room immediately on day of inspection by ED.*
- *Resident was educated by ADHW to notify a team member if █ needs a new medication on 4/9/2026.*
- *The DHW and ADHW conducted audit of resident records for all residents who self-administer medications to verify practitioner assessment present, assessment addresses ability and reminder needs, support plan reflects findings, and medication list is current. This was completed by 3/31/2026.*
- *The DHW and ADHW re-educated direct care staff and medication staff on the requirements of regulation 181c. This was completed by 4/10/2026. (SEE ATTACHED)*
- *Beginning 4/1/2026, the DHW and ADHW or designee will check 2 resident rooms weekly for 2 months then biweekly for 2 months to ensure compliance with regulation 181c. (SEE ATTACHED)*

Licensee's Proposed Overall Completion Date: 06/16/2026

Implemented (█ - 06/17/2026)**183b - Meds and Syringes Locked****7. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/17/26 at 2:43pm, a bottle of Tums was unlocked, unattended, and accessible in Resident 3's room.

Plan of Correction**Accept (█ - 06/11/2026)**

- *On 3/17/2026, the bottle of tums was removed from resident 3's room immediately on day of inspection by ED.*
- *Resident was educated by ADHW to notify a team member if he needs a new medication on 4/9/2026.*
- *An audit of all resident rooms occurred on 3/18/2026 to ensure all self-administered medications were maintained in a safe, secure, locked location in accordance with 183b.*
- *The DHW and ADHW re-educated all direct care staff, including staff certified or licensed to administer medication, on proper storage of prescription and OTC medications, requirement that medications in resident rooms remain locked, routine room monitoring for unsecured medications, and immediate corrective action when unsecured medications are identified. This was completed by 4/10/2026. (SEE ATTACHED)*
- *Beginning 4/1/2026, the DHW and ADHW or designee will check 2 resident rooms weekly for 2 months then biweekly for 2 months to ensure compliance with regulation 183b. (SEE ATTACHED)*

Licensee's Proposed Overall Completion Date: 06/16/2026

183b - Meds and Syringes Locked (continued)

Implemented () - 06/17/2026

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident 2 is prescribed Trazodone 50mg 1 tablet at bedtime. This medication was not administered to Resident 2 on 3/13/26 because the medication was not available in the home.

Repeat Violation: 2/27/25

Plan of Correction

Directed () - 06/10/2026

- Immediately upon identification of the deficiency, the Power of Attorney and Primary Care Provider were notified that Resident 2's Trazodone 50 mg was unavailable and the bedtime dose was missed on 3/13/26.
- Trazadone 50mg was obtained from the pharmacy for Resident 2 immediately and made available in the home for administration as prescribed.
- The missed dose was documented on the MAR, including the reason the medication was not administered, and the prescriber's instructions regarding follow-up care were documented in the resident's record.
- Resident 2 was monitored related to the missed dose and there were no adverse effects. The prescriber's orders were followed.
- On 3/26/2026, the DHW and ADHW completed a full audit of all resident medications and medication supply levels to ensure all prescribed medications are present in the home and available for timely administration.
- The DHW and ADHW re-educated all direct care staff and medication administration staff on the requirement to follow prescriber orders, timely medication reordering procedures, documentation of missed doses on the MAR, and immediate prescriber notification when a medication is unavailable. This was completed by 4/10/2026. (SEE ATTACHED)
- Starting 4/1/2026, the DHW, ADHW or designee will audit 2 residents' medications weekly for 3 months then biweekly for 3 months to ensure compliance with regulation 187d. (SEE ATTACHED)

Proposed Overall Completion Date: 04/10/2026

Directed: In addition to the above plan of correction, the administrator or designee will complete full medication cart audits monthly to verify that all medications are present. If any medication is not available, it will be immediately ordered.

Directed Completion Date: 06/16/2026

Implemented () - 06/17/2026

188b - Medication Error Reporting

9. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting (continued)

Description of Violation

Resident 2 is prescribed Trazodone 50mg 1 tablet at bedtime. This medication was not administered to Resident 2 on 3/13/26 because the medication was not available in the home. The medication error was not reported to the Power of Attorney, or the Primary Care Physician until 3/18/26.

Plan of Correction

Accept () - 06/11/2026

- Immediately upon identification of the deficiency, the Power of Attorney and the Primary Care Provider were notified that Resident 2's Trazodone 50 mg was unavailable and the bedtime dose was missed on 3/13/26.
- Trazodone 50mg was obtained from the pharmacy for Resident 2 immediately and made available in the home for administration as prescribed.
- The missed dose was documented on the MAR, including the reason the medication was not administered, and the prescriber's instructions regarding follow-up care were documented in the resident's record.
- Resident 2 was monitored related to the missed dose and there were no adverse effects. The prescriber's orders were followed.
- Reportable for the medication error for Resident 2 was submitted to DHS on 3/17/2026.
- On 3/26/2026, the DHW and ADHW completed a full audit of all resident medications and medication supply levels to ensure all prescribed medications are present in the home and available for timely administration.
- The DHW and ADHW re-educated all direct care staff and medication administration staff on the requirement to follow prescriber orders, timely medication reordering procedures, documentation of missed doses on the MAR, and immediate prescriber notification when a medication is unavailable. This was completed by 4/10/2026. (SEE ATTACHED)
- Beginning the week of 4/6/2026, the DHW, ADHW or designee will conduct weekly audits of 3 residents' medication administration records logs for 3 months, followed by bi-monthly audits for 3 months to ensure compliance with regulation 188b. (SEE ATTACHED)

Licensee's Proposed Overall Completion Date: 06/16/2026

Implemented () - 06/17/2026

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident 4's assessment, dated (), does not include their need for hospice services.

Plan of Correction

Accept () - 06/11/2026

- On 3/12/2026, Resident 4's assessment was immediately reviewed and updated to reflect the resident's current need for hospice services, including all related care needs, services provided, and coordination with the hospice agency.
- On 3/22/2026, The DHW and ADHW conducted an audit of all current residents receiving hospice services to ensure their assessments accurately reflect hospice involvement and related care requirements.
- The ED and DHW will re-educate Licensed nursing staff and all personnel responsible for resident assessments and the requirement to promptly update resident assessments whenever there is a significant change in condition or

225c Additional Assessment (continued)

service needs, including initiation of hospice services. This will be completed by 4/10/2026. (SEE ATTACHED)

- Starting 4/1/2026, the DHW and ADHW will audit the assessments for any new hospice admissions weekly for 4 weeks, then monthly for 2 months, to ensure ongoing compliance with regulation 225c. (SEE ATTACHED)

Licensee's Proposed Overall Completion Date: 06/16/2026

Implemented (█) - 06/17/2026

227d - Support Plan Medical/Dental**11. 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

Residents 5 and 6 are assessed as needing physical assistance transferring from their bed and chair. The residents' support plans dated █ do not reflect the specific need for the device, the intended use and any risks associated with the use; the resident's ability to use the device safely for the purpose it was intended, or identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction

Directed (█) - 06/11/2026

- On 3/17/2026, the support plans for Residents 5 and 6 were immediately reviewed and revised to include: the specific transfer device required, the clinical need for the device, the intended use, risks associated with use, the resident's ability to use the device safely as intended, and whether a cover is required in accordance with FDA guidelines.
- On 3/31/2026, the DHW and ADHW completed a full audit of all current resident support plans to identify residents using transfer or assistive devices to ensure documentation includes all required elements, including device specific information and safety considerations.
- The DHW and ADHW will re educate all staff responsible for completing and updating support plans on regulatory requirements for documentation of assistive and transfer devices, including safe use, risk assessment, and FDA cover requirements. This will be completed by 4/10/2026. (SEE ATTACHED)
- Starting 4/1/2026, the DHW and ADHW will perform weekly audits of 2 support plans involving assistive and transfer devices for 4 weeks, then monthly for 2 months, to ensure sustained compliance with regulation 227d. (SEE ATTACHED)

Proposed Overall Completion Date: 06/18/2026

Directed Completion Date: 06/16/2026

Implemented (█) - 06/17/2026