

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

June 2, 2026

[REDACTED]  
WOLF RUN VILLAGE LLC  
[REDACTED]

RE: WOLF RUN VILLAGE  
3750 ROUTE 220 HIGHWAY  
HUGHESVILLE, PA, 17737  
LICENSE/COC#: 22149

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/19/2026, 04/21/2026 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:** WOLF RUN VILLAGE **License #:** 22149 **License Expiration:** 07/24/2026  
**Address:** 3750 ROUTE 220 HIGHWAY, HUGHESVILLE, PA 17737  
**County:** LYCOMING **Region:** NORTHEAST

## Administrator

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

## Legal Entity

**Name:** WOLF RUN VILLAGE LLC  
**Address:** [REDACTED]  
**Phone:** [REDACTED] **Email:** [REDACTED]

## Certificate(s) of Occupancy

## Staffing Hours

**Resident Support Staff:** 0 **Total Daily Staff:** 64 **Waking Staff:** 48

## Inspection Information

**Type:** Partial **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Complaint, Incident **Exit Conference Date:** 03/19/2026

## Inspection Dates and Department Representative

03/19/2026 - On-Site: [REDACTED]  
 04/21/2026 - On-Site: [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

**License Capacity:** 75 **Residents Served:** 60

## 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:** 60  
**Diagnosed with Mental Illness:** 0 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 4 **Have Physical Disability:** 1

## Inspections / Reviews

03/19/2026 Partial

**Lead Inspector:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/21/2026

05/27/2026 - POC Submission

**Submitted By:** [REDACTED] **Date Submitted:** 05/29/2026  
**Reviewer:** [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 05/29/2026

Inspections / Reviews *(continued)*

06/02/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/29/2026

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

Resident [REDACTED] was prescribed [REDACTED] daily beginning [REDACTED]. The medication was not administered from [REDACTED] through [REDACTED]. The home did not report the medication error to the department.

#### Plan of Correction

Accept [REDACTED] - 05/27/2026)

Resident [REDACTED]'s [REDACTED] POA/retired RN had taken the resident to an appointment on 3/6/2026 and upon [REDACTED] return stated to the staff that [REDACTED] would be administering a newly prescribed cream. The order for the cream did not come to us from the provider, we contacted the pharmacy to get a copy of the order. The order was received from the pharmacy on 3/10/26 at 6:56am. The staff informed the [REDACTED] that the cream would likely arrive from the pharmacy the next day. The medication arrived with the delivery around 9:30PM on 3/10/26. On the day of the inspection the [REDACTED] was contacted about not starting the treatment. (see attached note) On 3/20/26 the prescriber sent an order for the medication to begin at the discretion of the [REDACTED]. The [REDACTED] was given the cream, and [REDACTED] kept the cream in [REDACTED] possession. [REDACTED] chose to begin the treatment the following week when [REDACTED] returned from being out of town. The [REDACTED] had the order discontinued on 4/13/26. On the day of the inspection the RASP was updated with the details of the new treatment and the incident report for the med error was completed and sent to DHS. On 3/19/26 the staff member was counseled on reporting med errors and why this is considered a med error. On 3/19/26, the administrator began to monitor the incoming orders to ensure the proper procedures are being followed for new orders. Monitoring will continue for three months. See Attached log, RASP Update and notes from resident chart.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [REDACTED] - 06/02/2026)

## 17 - Record Confidentiality

### 2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

#### Description of Violation

At approximately 9:15 a.m., a sheet of paper approximately 8 ½ x 11 in size with resident names and resident vital signs information was observed laying on the top of an unattended Medication Cart.

Repeat Violation [REDACTED]

#### Plan of Correction

Accept [REDACTED] - 05/27/2026)

On the day of inspection the med tech was reminded that the vital sheet must be kept in the top drawer of the locked med cart. The med tech was retrained on HIPAA on 3/20/26. HIPAA was also part of the staff training on 4/16/26 for all staff. Going forward HIPAA will be included in the additional training check list for all new med techs. The Administrator will audit the check list for each new med tech within a week of the completion of their training, See

17 Record Confidentiality (continued)

attached Training Record and checklist.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [redacted] - 06/02/2026)

187d - Follow Prescriber's Orders

3. Requirements

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

Description of Violation

Resident [redacted] was prescribed [redacted] on [redacted]. The medication was not administered from [redacted] through [redacted].

Repeat Violation [redacted]

Plan of Correction

Accept [redacted] 05/27/2026)

Resident #3's [redacted] POA/retired RN had taken the resident to an appointment on 3/6/2026 and upon [redacted] return stated to the staff that [redacted] would be administering a newly prescribed cream. The order for the cream did not come to us from the provider, we contacted the pharmacy to get a copy of the order. The order was received from the pharmacy on 3/10/26 at 6:56am. The staff informed the [redacted] that the cream would likely arrive from the pharmacy the next day. The medication arrived with the delivery around 9:30PM on 3/10/26. On the day of the inspection the [redacted] was contacted about not starting the treatment. (see attached note) On 3/20/26 the prescriber sent an order for the medication to begin at the discretion of the [redacted]. The [redacted] was given the cream, and [redacted] kept the cream in [redacted] possession. [redacted] chose to begin the treatment the following week when [redacted] returned from being out of town. The [redacted] had the order discontinued on 4/13/26. On the day of the inspection the RASP was updated with the details of the new treatment and the incident report for the med error was completed and sent to DHS. On 3/19/26 the staff member was counseled on reporting med errors and why this is considered a med error. On 3/19/26, the administrator began to monitor the incoming orders to ensure the proper procedures are being followed for new orders. Monitoring will continue for three months. See Attached log, RASP Update and notes from resident chart.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [redacted] - 06/02/2026)

188b - Medication Error Reporting

4. Requirements

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

Description of Violation

Resident [redacted] was prescribed [redacted] on [redacted]. The medication was not administered from [redacted] through [redacted]. The home did not immediately report to the resident, the resident's designated person and the prescriber.

## 188b - Medication Error Reporting (continued)

## Plan of Correction

Accept (█) 05/27/2026)

Resident █ POA/retired RN had taken the resident to an appointment on 3/6/2026 and upon █ return stated to the staff that █ would be administering a newly prescribed cream. The order for the cream did not come to us from the provider, we contacted the pharmacy to get a copy of the order. The order was received from the pharmacy on 3/10/26 at 6:56am. The staff informed the █ that the cream would likely arrive from the pharmacy the next day. The medication arrived with the delivery around 9:30PM on 3/10/26. On the day of the inspection the █ was contacted about not starting the treatment. (see attached note) On 3/20/26 the prescriber sent an order for the medication to begin at the discretion of the █. The █ was given the cream, and █ kept the cream in █ possession. █ chose to begin the treatment the following week when █ returned from being out of town. The █ had the order discontinued on 4/13/26. On the day of the inspection the RASP was updated with the details of the new treatment and the incident report for the med error was completed and sent to DHS. On 3/19/26 the staff member was counseled on reporting med errors and why this is considered a med error. On 3/19/26, the administrator began to monitor the incoming orders to ensure the proper procedures are being followed for new orders. Monitoring will continue for three months. See Attached log, RASP Update and notes from resident chart.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented (█) - 06/02/2026)

## 225c - Additional Assessment

## 6. Requirements

2600.

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

2. If the condition of the resident significantly changes prior to the annual assessment.

## Description of Violation

Resident █ utilizes a Hoyer Lift for transfers. The utilization of a Hoyer lift to transfer the resident is not noted in the resident's assessment dated █

Resident █'s current assessment dated █ has not been updated to indicate that beginning █ the prescribed █ will be administered by the resident's family member and where the medication will be stored.

Repeat Violation █

## Plan of Correction

Accept (█) - 05/27/2026)

Resident █ was on hospice. The hospice group brought the lift into the facility but did not initiate the use of the lift. The staff did not use the lift and the hospice group removed the lift on the day after the inspection.

Resident █'s █ POA/retired RN had taken the resident to an appointment on 3/6/2026 and upon █ return stated to the staff that █ would be administering a newly prescribed cream. The order for the cream did not come to us from the provider, we contacted the pharmacy to get a copy of the order. The order was received from the pharmacy on 3/10/26 at 6:56am. The staff informed the █ that the cream would likely arrive from the pharmacy the next day. The medication arrived with the delivery around 9:30PM on 3/10/26. On the day of the

**225c - Additional Assessment (continued)**

inspection the [REDACTED] was contacted about not starting the treatment. (see attached note) On 3/20/26 the prescriber sent an order for the medication to begin at the discretion of the [REDACTED]. The [REDACTED] was given the cream, and [REDACTED] kept the cream in [REDACTED] possession. [REDACTED] chose to begin the treatment the following week when [REDACTED] returned from being out of town. The [REDACTED] had the order discontinued on 4/13/26. On the day of the inspection the RASP was updated with the details of the new treatment and the incident report for the med error was completed and sent to DHS. On 3/19/26 the staff member was counseled on reporting med errors and why this is considered a med error. On 3/19/26, the administrator began to monitor the incoming orders to ensure the proper procedures are being followed for new orders. Monitoring will continue for three months. See Attached log, RASP Update and notes from resident chart.

Licensee's Proposed Overall Completion Date: 05/21/2026

Implemented [REDACTED] 06/02/2026)

**227c - Support Plan Revision****7. Requirements**

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

**Description of Violation**

Resident [REDACTED] most recent Resident Assessment and Support Plan (RASP) dated [REDACTED] includes an addendum dated [REDACTED] which indicates the resident requires some assistance with incontinence care and toileting. The home is doing 1-hour checks, but staff indicate that these are not enough and the resident is incontinent within the hour. The support plan has not been updated regarding how the home is going to meet the resident's needs.

**Plan of Correction**

Accept [REDACTED] - 05/27/2026)

This resident was frequently incontinent even with hourly assistance. The staff has relayed to the administrator that a lot of incontinence episodes occur when the resident is being transferred from chair to wheelchair to be taken to the bathroom.

On 10/21/25 the administrator began having conversations with the POA about the resident needing a higher care level than the facility could provide. The POA refused to move the resident to a skilled nursing facility.

On 4/9/26, the schedule was reviewed with the resident's POA who requested the schedule be changed to less frequent checks. On 4/30/26 a care conference was held, the care log was reviewed and the administrator changed the schedule back to hourly daytime checks with the objection of the POA noted. The checks during sleeping hours will remain the same. The staff is documenting all incontinent episodes to better understand when more care is needed. On 4/30/26 at 9:00PM an alert was set in the system to notify all staff of the change. Discussions with the POA about the resident needing a higher level of care began on October 21, 2025. The POA has been adamant that they will not move the resident to a skilled facility. Advisement that the resident requires more care than the facility is able to provide occurred on 10/21/25, 11/28/25, 12/9/25, 12/15/25, 1/23/26, 2/10/26, 3/8/26, 3/20/26, 4/3/26, 4/9/26 and 4/15/26 and met every time with an adamant no from the POA.

The administrator contacted AAA for assistance and was advised to have the PCP complete the MA-51 and fax it to them. On 4/2/26, the PCP completed the form and stated that the resident needs were appropriate for a skilled nursing facility. On 4/3/26, a care meeting was attended by the POA, the resident's other adult child and the administrator. During the conversation about the need for a higher care level the administrator advised the POA that the MA-51 had been sent to the PCP as AAA had requested. On 4/6/26, the PCP faxed a letter stating they had

**227c - Support Plan Revision (continued)**

*made an error and should have marked personal care home on the form. The administrator contacted AAA about the MA-51 and was told by AAA that they had also informed the POA that the resident needed skilled nursing.*

*On 4/13/26 the resident was admitted to hospice to provide additional care. On 4/13/26 the admitting hospice nurse assessed the resident and stated that the resident was a heavy, max 2 assist for toileting and is not sure a personal care home is appropriate. A lift was discussed and the nurse was advised that the facility is a NO Lift facility. On 4/30/26 a care conference was held with the hospice group, the POA and the Administrator. It was explained once again that the care level they were requesting is beyond the scope of services that this facility provides and that hospice only provides one aide two times a week and each time is for one hour. It was also explained that if hospice aides do come to provide care, the facility staff is still responsible for making sure the care is completed. The administrator advised the POA that a 30-day notice was being issued. The POA, with the hospice group present, finally stated that they would be moving the resident and would get back to the administrator with the facilities they should work with. After the meeting on 4/30/26, the administrator had a discussion with the resident about the need for a higher level of care. The resident stated that they understood and appeared to be agreeable to a move. A 30-day notice was hand delivered to the POA and the resident at that time and a copy was sent through certified mail. The administrator has asked the POA, on three different occasions, for a list of acceptable facilities to work with and has been told each time that they would let the administrator know when they are ready. Administrator will monitor daily tasks on a weekly basis until resident is discharged. The Hospice Social Worker contacted the administrator on 5/20/26 to let the facility know that the POA is scheduled to move the resident on 5/23/26 at 9am. On 5/21/26, the POA notified the receptionist that STEP transportation would be arriving around 10am on 5/22/26 to transport the resident to the resident's new home. Please see attached RASP Updates and documentation.*

**Licensee's Proposed Overall Completion Date:** 05/21/2026

**Implemented (** ██████████ **06/02/2026)**