Pennsylvania
Department of Human Services

Sent via email to: [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JULY 21, 2026

[redacted]
Attn: Licensing
[redacted]

RE: Clarks Summit Senior Living
950 Morgan Highway,
Clarks Summit, Pennsylvania 18411
Certificate: 228210

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 1st, 2026, and April 22nd, 2026, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (228210) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, and is made pursuant to <62 P.S. § 1026 (b)(1);(4) and 55 Pa. Code § 20.71(a)(2);(3);(5);(6) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: [redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Clarks Summit Senior Living is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

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:** *92* **Waking Staff:** *69*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *05/22/2026*

Inspection Dates and Department Representative

04/01/2026 On Site: [redacted]

04/22/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served:** *81*

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:** *81*

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

Have Mobility Need: *11* **Have Physical Disability:** *0*

Inspections / Reviews

04/01/2026 - Partial

Lead Inspector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/07/2026*

06/29/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/06/2026*

07/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2026*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

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 sent to the hospital and admitted for treatment after having had a fall in the bathroom on [redacted] The incident was not reported to the department.

Repeated Violation: [redacted] et al.

Plan of Correction ***Directed [redacted] - 06/10/2026)***

• On June 1st, 2026, after the Executive Director (ED) reviewed the incident involving Resident [redacted] on February 23rd, 2026 and confirmed the required report had not been submitted to the Department, the ED submitted a reportable incident to the Department via email on this date.
• As of June 4, 2026, the ED re-educated the management team and all nurses on the requirements of regulation 16c.
• Starting the week of June 8th, 2026, the ED or designee will audit incident reports three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks to ensure ongoing compliance with regulation 16c. Any identified concerns will be addressed immediately including corrective action and additional staff education as needed.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, all employees will be educated on mandatory reporting requirements and the home's specific reporting policy and procedures.

Directed Completion Date: *07/06/2026*

Implemented [redacted] - 07/14/2026)

23a Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The home's practice is to complete 2-hour checks on all residents. In July 2025 and September 2025 the staff were trained on requirements for completing 2-hour checks. Training materials indicate that staff shall conduct resident checks at least every 2 hours, 24 hours a day unless the resident's support plan states otherwise. Resident [redacted] assessment and support plan dated [redacted] does not indicate that the resident does not require 2 hour checks. Staff A, B, C, and D all signed the training document indicating they attended the trainings and also worked on the night of [redacted]. During the interview with staff person D, they indicated that they did not complete 2-hour checks on Resident [redacted] on the night of [redacted] and the morning hours of [redacted] Resident [redacted] was outside unattended from 9:17 p.m.,

23a - Activities of Daily Living Assistance (continued)

until being found on the ground at 4:56 a.m.

Repeated Violation: [redacted]

Plan of Correction ***Directed*** [redacted] ***06/12/2026)***

• On March 29th, 2026, immediately upon discovery of Resident [redacted] *the resident was assessed, 911 was called and staff remained with resident until the resident was transported to the hospital where the resident passed away.*
• As of April 1st, 2026, the Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) completed an audit of current residents' assessments and support plans (RASPs) to ensure required monitoring interventions, including frequent checks where applicable, were accurately identified.
• Starting April 15th, 2026, the facility has revised its monitoring and documentation procedures related to resident safety checks. Staff are now required to document all scheduled safety checks on designated monitoring forms. Nursing Supervisors will review completed documentation daily from the prior day to ensure checks are conducted as required and properly recorded.
• As of June 3, 2026, re-education was provided to all direct care staff regarding:
? Regulation 23a
? Resident supervision expectations
? Completion and documentation of frequent checks
? Responsibilities related to resident safety and monitoring
? Immediate reporting of safety concerns, including a missing resident
• Starting the week of June 8th, 2026, the DHW, ADHW or designee will conduct weekly audits of 5 residents' monitoring documentation and RASPs for 90 days then bi-monthly for 90 days to ensure ongoing compliance with regulation 23a.
• Starting the week of June 15th, audit findings will be reviewed during management and quality assurance meetings to identify trends, ensure sustained compliance, and implement additional corrective actions, if necessary. Failure to follow resident monitoring procedures will result in disciplinary action, up to and including termination.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, the administrator or designee will train all staff to report changes in resident behaviors. The administrator or designee will then do an assessment on the resident and determine if increased safety checks are required.

Directed Completion Date: *07/06/2026*

Not Implemented [redacted] ***- 07/14/2026)***

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident [redacted] *is a mobile resident with a fall history and increased confusion that began on* [redacted] *as documented in*

42b Abuse (continued)

the resident record. The home's training of staff requires Resident [redacted] to be checked every 2 hours. On [redacted] at 4:54 p.m., Resident [redacted] was seen on the home's outdoor surveillance video exiting the home with their walker and proceeding to a bench in front of the building. The video shows that the Resident was last seen by staff at 9:17 p.m. Video then shows the Resident falling at 10:26 p.m. and remained on the ground until being discovered at 4:56 a.m. by Staff Person B. Staff Person E indicated that they went outside to administer Resident [redacted] medications at 9:17 p.m., and that the resident was cold and shivering but they could not get the resident to come inside the home as they were smoking. Staff Person E Informed Staff Person F that the resident was still outside after medications were administered. Staff Person F's shift ended at 10:00 p.m. and Staff Person E's shift ended at 11:00 p.m. Both staff person's left without telling anyone else the resident was still outside. Staff Person D worked on 2nd floor from 7:00 p.m. on [redacted] from 7:00 p.m. until 7:00 a.m. on [redacted] and was assigned to care for Resident [redacted] It was their responsibility to complete 2 hour checks on all residents that reside on the 2nd floor including Resident [redacted] Staff Person D states that they tried to check on Resident [redacted] one time. However, the resident's door was locked, and they failed to ask the Medtech for a key to check on them. At no other time during their shift, did they try to check on Resident [redacted] or see the resident until they were discovered on the ground outside at 4:56 a.m. by Staff Person B. An ambulance arrived at 5:10 a.m. and transported the resident to the hospital, where they died at approximately 5:45 a.m.

Plan of Correction ***Directed [redacted] - 06/10/2026)***

• On March 29th, 2026, immediately upon discovery of Resident [redacted] the resident was assessed, 911 was called and staff remained with resident until the resident was transported to the hospital where the resident passed away. The leadership team immediately initiated an internal investigation.
• On March 30th, Staff Persons D, E, and F were suspended pending an investigation. All 3 employees were subsequently terminated effective May 29th, 2026.
• As of April 20th, 2026, any residents identified as having any of the following were reassessed using the DSL assessment for levels of care:
o confusion,
o elopement risk,
o smoking supervision needs,
o fall history, or
o required safety checks
• On April 1st, 2026 the DHW and ADHW completed an audit of current residents' RASPs and monitoring requirements to identify residents requiring frequent checks, behavioral monitoring, smoking supervision, fall interventions, wandering precautions, increased supervision and any discrepancies identified were immediately corrected and updated in the resident record and support plan.
• As of March 29th, 2026, new supervisory walking rounds were initiated by the DHW to be conducted at least once per shift for 90 days.
• Between April 1st and April 30th, ED and Facilities Director reviewed outdoor monitoring and smoking supervision procedures with all staff following the incident and decided that the facility will become a non smoking community effective June 23, 2026.
• As of March 30th, and until the community becomes smoke free on June 23rd, 2026, the facility revised outdoor smoking and supervision procedures to include:
o routine visual monitoring of residents outdoors,
o designated staff responsibility for outdoor resident awareness,
o documentation of residents refusing to come inside
• As of June 4th, all staff, including direct care staff, medication technicians, supervisors, and leadership team, received mandatory retraining on:
o Resident rights under 2600.42B

42b Abuse (continued)

o Neglect prevention
o Resident supervision requirements
o Mandatory reporting responsibilities
o Shift to shift communication expectations
o Monitoring and documentation requirements
o Fall prevention and response
o Smoking safety supervision
o Emergency response procedures
The above training also emphasized that residents requiring safety checks must be physically located and visually observed, locked resident room doors do not eliminate staff responsibility to verify resident safety and staff may not leave the building or end the shift without communicating unresolved resident safety concerns to incoming staff and supervisor.
• As of June 1st, 2026, all newly hired staff will receive this training during orientation.
• As of April 1st, 2026, the facility implemented a mandatory verbal and written shift to shift report process that will be reviewed by the supervisor and it includes:
o residents outside the building,
o residents requiring monitoring,
o behavior changes,
o fall risks,
o residents refusing care, and
o unresolved safety concerns.
• As of June 5th, the DHW and ADHW reviewed the following with all direct care staff:
o documented frequent checks,
o visual verification of resident location and condition,
o supervisor review of completed rounds each shift,
o immediate escalation of missed checks.
• Starting the week of June 8th, 2026, the DHW, ADHW or designee will conduct weekly audits of 5 residents' monitoring documentation and RASPs as well as the shift to shift forms for that week for 90 days then bi monthly for 90 days to ensure ongoing compliance with regulation 42b.
• Starting June 15th, ED or designee will review as part of the quality assurance meetings related to resident supervision and safety.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, the administrator or designee will review the shift-to-shift report daily. Any change in behaviors or exit seeking will be reviewed and a new determination on safety check frequency will be completed. The resident assessment and support plan will then be updated with changes in required time frames and all staff made aware of changes if any in the frequency of safety checks.

Directed Completion Date: *07/06/2026*

Not Implemented [redacted] - 07/14/2026)

60a - Staff/Support Plan

4. Requirements

60a - Staff/Support Plan *(continued)*

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Staff Person B left the building from 4:45 a.m. until 4:56 a.m. During that time, there were only 3 staff in the home. The home had a census of 78 residents, including 11 immobile residents with 6 of them requiring the assistance of 2 staff for transferring. The Resident bedrooms are spread over 3 floors in the home. 3 staff would not be able to safely evacuate all of the residents in the event of an emergency.

Plan of Correction ***Directed [redacted] - 06/10/2026)***

• On June 2nd, 2026, Staff Person B received counseling regarding the requirement to remain on duty and in the building during scheduled work hours unless relieved by another qualified staff member and approved by the supervisor on duty.
• On May 30th, 2026, ADHW reviewed current residents' RASPs, mobility status, and evacuation needs to verify necessary staffing levels to meet current resident needs as stated in regulation 60a. This information was shared with the ED.
• On May 30th, 2026, the Executive Director (ED) reviewed the staffing schedule and staffing assignments to ensure adequate coverage is maintained at all times to be compliant with regulation 60a.
• As of May 28th, 2026, the facility revised its staffing procedures to prohibit staff from leaving the building during scheduled shifts unless relieved by another qualified staff member and approved by the supervisor on duty.
• All staff will be trained on regulation 60a by June 4th, 2026 by the Executive Director.
• Starting the week of June 8th, 2026, the ED, DHW or designee will conduct random audits of staffing schedules, staffing assignments, and time records weekly for 90 days then bi-monthly for 90 days to ensure ongoing compliance with regulation 60a. Any identified concerns will be addressed immediately through retraining and/or disciplinary action as appropriate.
• Starting June 15th, 2026, audit findings will be reviewed during management meetings to identify trends and ensure ongoing compliance.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, the administrator or designee will review the staffing schedule weekly to ensure that enough staff are scheduled to meet the resident needs and evacuate residents in time specified in writing within the last year by a fire safe expert. Any staff that calls off for their shift, leaves early, or arrives late for their shift will be replaced by another worker.

Directed Completion Date: *07/06/2026*

Not Implemented [redacted] - 07/14/2026)

182c - Medication Administration

5. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

182c - Medication Administration *(continued)*

Description of Violation

At 9:17 p.m., Staff Person E administered medications to Resident [redacted] outside the home on the bench near the front parking lot. Staff Person E did not administer the medication in the vicinity of the medication cart.

Plan of Correction ***Directed [redacted] - 06/12/2026)***

• On March 30th, 2026, Staff Person E was suspended immediately pending investigation and was subsequently terminated on May 29, 2026.
• By June 5th, 2026, the ADHW retrained all staff who are licensed or certified to administer medications on proper medication administration procedures including regulation 182c.
• Starting the week of June 8th, 2026, the DHW, ADHW or designee will conduct medication administration observations with 3 staff who are licensed or certified to administer medications weekly for 4 weeks and then biweekly for 4 weeks then monthly for 1 month to ensure compliance with medication administration procedures and regulation 182c. Any identified concerns will result in immediate corrective action, counseling, and retraining as appropriate.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, the administrator or designee will interview 2 residents per week for 4 weeks regarding how and where their medications are being administered.

Directed Completion Date: *07/06/2026*

Not Implemented [redacted] - 07/14/2026)

201 - Positive Interventions

7. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Residents [redacted] assessment and support plan dated [redacted] indicates under understanding instructions that direct care staff will continue to attempt to redirect and educate on risks and importance of all safety measures regarding using walker properly, going outside after dark, and weather advisories. Interviews with Staff Persons A, B, C, and D verified that Resident [redacted] would go outside at all hours of the day or night to smoke, regardless of weather conditions. During a staff interview, Staff Person F reported seeing Resident [redacted] outside in rainstorms. The staff was aware of the residents' unsafe behaviors of going outside to smoke, regardless of inclement weather or time of day but did not put any safeguards in place to ensure their safety.

Plan of Correction ***Directed [redacted] - 06/12/2026)***

• On April 2nd, 2026, the ED, DHW and ADHW conducted a review of all residents to identify if any engage in behaviors that may place them at risk for injury. No residents were identified as engaging in behaviors which could harm themselves or others.

201 - Positive Interventions (continued)

• On April 2nd, 2026, the ED and DHW reviewed the community's procedures regarding safe management techniques, behavior interventions, resident supervision, and support plan implementation to ensure:
o Identified risks are addressed through individualized interventions.
o Staff consistently implement and document redirection, de-escalation, and other positive intervention techniques.
o Changes in resident behaviors are communicated to management and interdisciplinary team members promptly.
o Assessments and support plans are updated when new safety concerns are identified.
• By June 4th, the ED will provide training to all staff on the following:
o Regulation 2600.201 Safe Management Techniques.
o Implementation of residents' needs as identified in the RASP
o Positive intervention and redirection techniques.
o Documentation requirements for behavioral and safety interventions.
o Monitoring and responding to resident behaviors that present a risk to health and safety.
• Starting June 8th, 2026, the DHW, ADHW or designee will audit 5 residents' RASPs to ensure they accurately reflect identified safety risks and staff are implementing the prescribed interventions and, if applicable, new safety concerns are documented and addressed timely weekly for 12 weeks.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, the administrator or designee will train all staff to report changes in resident behaviors. The administrator or designee will then determine additional safe management techniques to be utilized if needed and inform all staff of the changes.

Directed Completion Date: *07/06/2026*

Not Implemented [redacted] - 07/14/2026)

225c - Additional Assessment

8. 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

Through the review of staffing notes, it indicated that Resident [redacted] had increased confusion beginning on [redacted] The resident also had numerous falls, some of which required hospitalization. The change in level of cognition and fall history were not documented on the residents' assessment and support plan dated [redacted].

Repeated Violation: [redacted].

Plan of Correction ***Directed [redacted] - 06/12/2026)***

• By June 7th, 2026, the DHW, ADHW or designee will complete a review of current residents to identify if there are any changes in condition that require updates to the resident's RASP. Any identified deficiencies will be corrected immediately.
• By June 7th, 2026, the ED will provide re-education to all direct care staff regarding the requirements of regulation 225c, including the responsibility to promptly communicate significant changes in a resident's condition, cognition,

225c Additional Assessment (continued)

behavior, mobility, or fall status to the DHW or ADHW so that RASPs can be updated timely.
• Starting the week of June 8th, 2026, the DHW, ADHW or designee will choose 5 residents to speak with staff about their needs and review those residents' RASPs with the staff weekly for 12 weeks to ensure accuracy and compliance with regulation 225c. Audit findings will be reviewed with the Executive Director (ED) then retraining and corrective action will be implemented as necessary.

Proposed Overall Completion Date: 06/05/2026

Directed: In addition to the above plan of correction, the administrator or designee will ensure that all staff are made aware of any changes made to a resident assessment and support plan.

Directed Completion Date: *07/06/2026*

Not Implemented [redacted] 07/14/2026)