

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

May 14, 2026

[REDACTED] VP OF OPERATIONS
HOMEWOOD LIVING SPRING HOUSE INC.
[REDACTED]
[REDACTED]

RE: HOMEWOOD LIVING SPRING
HOUSE INC.
150 VICTORIA AVENUE
EVERETT, PA, 15537
LICENSE/COC#: 33510

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/01/2026 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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HOMEWOOD LIVING SPRING HOUSE INC.* License #: *33510* License Expiration: *09/19/2026*
 Address: *150 VICTORIA AVENUE, EVERETT, PA 15537*
 County: *BEDFORD* Region: *CENTRAL*

Administrator

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

Legal Entity

Name: *HOMEWOOD LIVING SPRING HOUSE INC.*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *Other* Date: *09/14/2009* Issued By: *Commonwealth Code Inspection, Bedford County*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *34* Waking Staff: *26*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Incident* Exit Conference Date: *04/01/2026*

Inspection Dates and Department Representative

04/01/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *52* Residents Served: *28*

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

Hospice
 Current Residents: *2*

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: *6* Have Physical Disability: *2*

Inspections / Reviews

04/01/2026 Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/23/2026*

04/23/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *05/13/2026*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/30/2026*

Inspections / Reviews *(continued)*

04/23/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/13/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/15/2026

05/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/13/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

42s - Privacy

1. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Multiple cameras video record in the common areas of the home including in the dining area, hallway and activity area of the personal care are labeled the "neighborhood".

Plan of Correction

Accept () - 04/23/2026

On April 15, 2026, Security, the facility's third party security provider, was notified and directed to disable all security cameras in the PC Neighborhood that record the activity and dining areas. The Administrator is responsible for ensuring compliance. Monthly Quality Assurance audits will be completed to verify that no security cameras are recording in resident spaces. Audits will be conducted for 3 months, and findings will be documented on the attached audit form. Any identified issues will be addressed immediately. Audit start date 4/22/2026.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented () - 05/14/2026

103f - Refrigerator/Freezer Temps

2. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the freezer located to the immediate left of the ovens in the kitchen.

Plan of Correction

Accept () - 04/23/2026

On April 8, 2026, new refrigerator and freezer thermometers were ordered and installed by the Maintenance Director in all facility refrigerators and freezers. Thermometers were securely installed either on the interior side wall or attached to the wire racks on the same date. (See attached photo of the freezer identified during survey with a missing thermometer.)

To prevent reoccurrence, the Dining Director will complete weekly audits to ensure all refrigerators and freezers contain a functioning internal thermometer. A Quality Assurance checklist has been affixed to the exterior of each appliance and requires the Dining Director to audit and initial weekly verification. This monitoring process will continue through July 15, 2026. If a thermometer is found to be missing or nonfunctional, the Dining Director will immediately notify Maintenance for replacement. Spare thermometers are maintained in the maintenance supply room for prompt replacement. In the absence of the Dining Director, the Administrator will complete the audit. (See attached checklist.)

Education was provided to dietary and maintenance staff on April 9, 2026, regarding regulatory requirements, the importance of temperature monitoring in refrigerators and freezers, and the ongoing audit process.

103f Refrigerator/Freezer Temps (continued)

Audit start date 4/15/26.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented (█) - 05/14/2026)

121a - Unobstructed Egress

3. Requirements

2600.

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

Description of Violation

On 4/1/26 at 9:57 AM, the exit door located in the PC neighborhood dining room leading to the courtyard, was locked with a key lock deadbolt. The door is labeled as an exit. Staff Member A confirmed this is an exit as it leads to the courtyard, and the courtyard has a gate leading outside the home. Staff Member A stated this exit is locked overnight.

Plan of Correction

Accept (█) - 04/23/2026)

On April 8, 2026, the Facility Maintenance Director contacted █ Contractors to remove the deadbolt locking device from the PC Neighborhood Courtyard door and replace it with a push bar locking mechanism. The proposed improvements were reviewed and approved and are scheduled for installation upon receipt of required parts. (See attached proposal.)

To prevent reoccurrence, the Administrator will complete monthly Quality Assurance audits to ensure all facility doors maintain appropriate locking devices. Audits will be conducted for a period of three months and documented using the attached audit form. Facility administrator will complete audits from 4/22/26 through 7/22/26. Staff were educated on regulation 121.a on 4/9/26 by administrator and the importance of allowing emergency exits to be functional.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented (█) - 05/14/2026)

125a - Combustible Storage

4. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 4/1/26 at 1:47 PM, there were several cardboard boxes leaning against the boilers in the boiler room.

Plan of Correction

Accept (█) - 04/23/2026)

On April 1, 2026, the Facility Maintenance Director removed all cardboard boxes and other combustible materials

125a Combustible Storage (continued)

from the boiler area. (See attached photos.)

To prevent reoccurrence, the Maintenance Director will conduct weekly Quality Assurance audits to ensure that boilers remain free of flammable or combustible materials. Audits will be conducted for a period of three (3) months and will conclude on July 15, 2026. In the absence of the Maintenance Director, the Administrator will complete the audit. Audit findings will be documented using the attached audit form.

Education was provided to applicable staff on April 9, 2026, regarding regulatory requirements, the importance of maintaining clear boiler areas, and the audit process.

Audit process began on 4/16/26 by maintenance director.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented () - 05/14/2026

141a - Medical Evaluation

5. 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 initial medical evaluation, dated () does not include if the resident's needs can be met safely in a personal care home.

Plan of Correction

Accept () - 04/23/2026

The Resident Services Director provided education to physicians, physician assistants, and CRNPs regarding the importance of completing medical evaluations in their entirety. Education was completed via telephone on April 15, 2026.

To ensure ongoing compliance, the Resident Services Director will audit every completed medical evaluation for all residents to verify full completion. Audits will be conducted for a period of three (3) months and will conclude on July 15, 2026. Audit findings will be documented using the attached audit form.

Resident #1's med eval was corrected on 4/8/26 via resident services director verbal clarification by physician.

On 4/9/26 staff were educated by administrator and resident services director on regulation 141.a and the importance of reviewing all medical evals for completion by physicians before filing them in residents charts.

Audit date began 4/8/26.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented () - 05/14/2026

141b1 - Annual Medical Evaluation

6. Requirements

141b1 - Annual Medical Evaluation (continued)

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation, dated [REDACTED] does not include if the resident's needs can be met safely in a personal care home.

Resident #3's most recent medical evaluation, dated [REDACTED] does not include if the resident's needs can be met safely in a personal care home.

Repeated Violation - 9/17/24

Plan of Correction

Accept ([REDACTED] - 04/23/2026)

The Resident Services Director provided education to physicians, physician assistants, and CRNPs regarding the importance of completing medical evaluations in their entirety. Education was completed via telephone on April 15, 2026.

To ensure ongoing compliance, the Resident Services Director will audit every completed medical evaluation for all residents to verify full completion. Audits will be conducted for a period of three (3) months and will conclude on July 15, 2026. Audit findings will be documented using the attached audit form.

Resident #2 and #3's med eval were corrected on 4/8/26 via resident services director verbal clarification by physician.

On 4/9/26 staff were educated by administrator and resident services director on regulation 141.b.1 and the importance of reviewing all medical evals for completion by physicians before filing them in residents charts. Audit date began 4/8/26.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented ([REDACTED] - 05/14/2026)

184b - Labeling OTC/CAM

7. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 4/1/26 at 1:30 PM, a package of Preser-vision and Probiotics belonging to Resident #4 was in the medication cart and was not labeled with the resident's name.

Plan of Correction

Accept ([REDACTED] - 04/23/2026)

The Resident Services Director will conduct weekly audits for a period of three (3) months on a random sample of ten percent (10%) of resident medications to ensure all medications are labeled with the resident's name. If any medications are found to be unlabeled, the resident's pharmacy of choice will be notified immediately. Audit findings will be documented using the attached audit form.

184b - Labeling OTC/CAM (continued)

Education was provided to applicable staff on April 9, 2026, regarding regulatory requirements and the importance of ensuring all medications are correctly labeled.

On 4/1/26 resident services director and medicine technician printed a label for OTC medication that included residents name, date, doctor, room number, DOB, and medication directions that were all compared to the residents order from physician.

Audit began on 4/8/26 by Resident Services Director.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented (█) - 05/14/2026)

185a - Implement Storage Procedures**8. 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 #6 is prescribed Macrobid 100 mg capsules with orders to take one capsule by mouth twice daily for up to 3 days for pending results of urine analysis and culture as needed. On 4/1/26, this medication was not available in the home.

Plan of Correction

Accept (█) - 04/23/2026)

The Resident Services Director will complete weekly audits for a period of three (3) months on a random sample of ten percent (10%) of PRN medications to ensure all PRN medications are available for resident use. Audit findings will be documented using the attached audit form.

Education was provided to all medication technicians on April 9, 2026, regarding regulatory requirements and the importance of ensuring PRN medications are available as ordered. Education also reinforced expectations for timely follow up with the pharmacy when medications are not received as expected and the requirement to immediately notify the Resident Services Director if a PRN medication is unavailable.

For the identified incident, the resident's pharmacy was notified to provide the required PRN medication.

Resident Services Director reordered medication on 4/1/26 and it arrived to the home on 4/2/26.

Audit began 4/8/26 by resident services director.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented (█) - 05/14/2026)

187d - Follow Prescriber's Orders**9. Requirements**

2600.

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

187d - Follow Prescriber's Orders (continued)

Description of Violation

Resident #5 is prescribed Prednisone 10 mg tablet with orders to take one tablet daily by mouth for [REDACTED] between 6:00 AM and 11:00 PM. However, Resident #5 was not administered this medication from 2/20/26-2/23/26.

Plan of Correction

Directed ([REDACTED] - 04/23/2026)

The Resident Services Director provided regulatory education to applicable staff regarding required procedures for reporting missing medication on April 9, 2026. Corrective action, consistent with facility policy, was taken to address failure to follow medication reporting procedures.

The Resident Services Director will provide additional education to medication technicians on the use of the "Missed Medication Report" (MMR), which identifies medications that were not administered or were not signed off appropriately. Medication technicians are required to run the MMR at the end of each shift, print the report, and maintain it at the nurses' station.

To ensure ongoing compliance, the Resident Services Director will audit MMR documentation on four (4) random days per week to verify that medications are accounted for and that reports are completed correctly. This monitoring process will continue for a period of three (3) months and will conclude on July 18, 2026.

Audit started on 4/8/26 by resident services director.

Directed Completion Date: 05/15/2026

Implemented ([REDACTED] - 05/14/2026)

251b - Record Entries Legible

10. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on the date of admission agreement for Resident #1.

Correction fluid was used on the time of the report and time of oral report to local law enforcement for an [REDACTED] report, dated 10/21/25, for Resident #6.

Plan of Correction

Accept ([REDACTED] - 04/23/2026)

The Administrator will monitor facility documentation to ensure correction fluid is not used in resident records. To ensure compliance, the Administrator will audit five (5) random resident record documents weekly to verify that correction fluid has not been used. Audits will continue through July 15, 2026.

The Administrator provided education to applicable staff on April 9, 2026 regarding regulatory requirements, the inappropriate use of correction fluid, and the proper method for correcting documentation errors in the medical record

Audit began 4/15/26 by administrator.

Licensee's Proposed Overall Completion Date: 05/15/2026

251b Record Entries Legible *(continued)*

Implemented (█) - 05/14/2026

252 Record Content

11. Requirements

2600.

252. Content of Resident Records Each resident's record must include the following information:

- 2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #2's record does not include color of hair, color of eyes, or identifying marks.

Plan of Correction

Accept (█) - 04/23/2026

On 4.2.26 Resident Services Director and Administrator have added hair color, eye color and identifying marks to the RASP template as a permanent question for staff to answer when completing the RASP moving forward. Resident Services Director will audit all RASPS and residents' charts to ensure all current residents are documented properly. Moving forward an audit will also be completed now through 7.15.26 to ensure eye color, hair color, and identifying marks are completed on the RASP of new residents and documents. Staff education was provided on 4.9.26. (See audit form.)

On 4/1/26 resident services director added resident's hair and eye color and identifying marks to residents' facesheet. Audit began 4/8/26 by resident services director.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented (█) - 05/14/2026