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

May 5, 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 04/07/2026 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

Type: *I-2* **Date**: *11/12/2009* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *6* **Total Daily Staff**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *04/07/2026*

Inspection Dates and Department Representative

04/07/2026 - 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

04/07/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/27/2026*

04/27/2026 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/04/2026*

Inspections / Reviews *(continued)*

05/05/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *05/05/2026*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

05/05/2026 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *05/05/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

23a - Activities of Daily Living Assistance

1. 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 assessment and support plan, dated [redacted] for Resident [redacted] indicates the resident requires assistance with toileting. On [redacted], an addendum indicated direct care staff will check Resident [redacted] every hour while awake and every 2 hours while sleeping for toileting assistance. Interviews indicated that the resident is not toileted as required by the assessment and support plan and was often found wet when checked according to the observation notes.

Repeat Violation: [redacted].

Plan of Correction ***Accept ([redacted] - 05/05/2026)***

On 3/19/26 under the suggestion of a DHS representative, the documentation of the assistance was switched from a paper log in the resident's bathroom to documentation in the new electronic health record software. The schedule was in the system but the ability for staff to document was not. This was corrected at the time of the inspection and all documentation is being completed for assistance with toileting as well as if there was an incontinence episode. This resident was frequently incontinent even with hourly assistance. The staff has relayed to the administrator that a lot of the incontinence episodes are occurring when the resident is being transferred from chair to wheelchair to be taken to the bathroom. 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. On 4/30/26 at 9:00PM an alert was set in the system to notify all staff of the change. Documentation for the schedule change began 5/1/26. 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, 11/28/56, 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. 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. I advised the POA that I would be issuing a 30 day notice. The POA with the hospice group present finally stated that they would get back to me with the facilities that I 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. Administrator will monitor daily tasks on a weekly basis until resident is discharged. Please see attached RASP Update and documentation.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] - 05/05/2026)

187a - Medication Record

2. Requirements

2600.

187a Medication Record *(continued)*

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

On [redacted], Staff Person A gave resident [redacted]'s [redacted] to be put on the resident. This medication is not documented on the Medication Administration Record.

Plan of Correction ***Accept [redacted] 05/05/2026)***

On 4/2/26 The resident had just returned from the ER after a fall where they sustained an abrasion on their forehead. The [redacted] (a retired RN) requested triple antibiotic ointment from the med tech on duty, to put on the abrasion. As the staff had been certified in basic first aid, they gave the [redacted] the triple antibiotic ointment to use on the abrasion. There was no documentation from the hospital discharge for this treatment. Upon further investigation, on 4/7/26 staff found that the resident had their own triple antibiotic in their room. The ointment was removed from the room. on 4/7/26, the staff was directed that they may not give anyone anything for a resident as an order will have to be provided from a doctor before it can be administered. The administrator is working to obtain an order from every resident's PCP in order for the staff to be able to provide basic first aid when needed. Most residents are seen by the same PCP and their orders were received on 4/23/26. All others were faxed to the PCPs by 4/29/26 and we are still waiting for a few of them to be returned. Going forward the order to administer basic first aid will be included with the request for all new resident's orders. See Attached Sample The orders will be entered as a PRN Treatment on the MAR. See Attached Administrator will check for these orders when completing MAR audits each month.

Licensee's Proposed Overall Completion Date: *05/04/2026*

Implemented ([redacted] - 05/05/2026)