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

June 16, 2026

[redacted], CEO
JAI JALARAM CARE LP
2015 NORTH READING ROAD
DENVER, PA, 17517

RE: FAITHFUL LIVING
2015 NORTH READING ROAD
DENVER, PA, 17517
LICENSE/COC#: 32258

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/14/2026, 04/14/2026 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *FAITHFUL LIVING* **License #**: *32258* **License Expiration**: *03/21/2027*

Address: *2015 NORTH READING ROAD, DENVER, PA 17517*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *JAI JALARAM CARE LP*

Address: *2015 NORTH READING ROAD, DENVER, PA, 17517*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/03/1985* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *80* **Waking Staff**: *60*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *04/15/2026*

Inspection Dates and Department Representative

04/14/2026 - On-Site: [redacted]

04/14/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *67*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *6* **Are 60 Years of Age or Older**: *62*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *13* **Have Physical Disability**: *2*

Inspections / Reviews

04/14/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/15/2026*

05/18/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/25/2026*

Inspections / Reviews *(continued)*

05/27/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/15/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/19/2026*

06/16/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/15/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

18 Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Care Facility Carbon Monoxide Alarm Standards Act, effective September 2016, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labelled with the date of installation and be replaced at least once annually. On 4/14/26, the CO alarm Located in the kitchen, labeled "#1", had a label stating, "new battery 12/15/24, tested 5/30/25." The CO alarm located in the storage room next to the kitchen, labeled "#2, had a label stating, "replaced 12/15/24, tested 5/30/25."

Repeated Violation - 4/29/25, et al.

Plan of Correction ***Accept ([redacted] - 05/18/2026)***

1. All CO2 monitors are tested on a weekly basis and a log is kept. New batteries were installed by the Dir of Environmental Services on 4/13/26. Labels reflecting this date were put on the detectors on 4/15.
2. Dir of Environmental Services educated on the requirements of this regulation on Dir of Environmental Services by the PCHA.
3. A calendar reminder will be put on to change batteries annually. These dates will be logged on the testing form.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented ([redacted] - 06/16/2026)

42b Abuse

2. 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

On 3/2/26, Staff Member A was assisting Resident #1 with logging [redacted] rent payment into the resident's checkbook ledger. When looking at the resident's checkbook ledger, Staff Member A observed information for a check written for $400.00 to Staff Member B. Staff Member A asked Resident #1 about the check, and the resident responded that Staff Member B had needed money to have vehicle fixed. Text messages exchanged between Resident #1 to Staff Member B revealed Staff Member B had requested $400.00 as well as an additional $127.00 for Staff Member B's car insurance. Resident #1 reported feeling taken advantage of by Staff Member B. According to the resident, Staff Member B had initially requested $500.00. Resident #1 told Staff Member B that [redacted] could only give staff $400. Resident #1 said [redacted] felt foolish for being taken advantage of by Staff Member B. As a result of the incident, Staff Member B was terminated on [redacted]

42b Abuse (continued)

Plan of Correction ***Directed (- 05/27/2026)***

1. Staff Member B was immediately suspended on pending investigation and terminated on . All reporting to the resident, Designated Person, PCP, DHS, Office of Aging, and the police department were done timely and in accordance with regulatory requirements. Due to the fact that the resident is alert and oriented x3 and is own decision maker, the police decided not to pursue any additional prosecution.
2. All Team Members are educated on Abuse and Financial Misuse of Resident Funds upon hire and at least annually.
3. All Team Members were educated on the home's policy on gifting and this regulation on 3/4 by the PCHA.
4. All team members were educated on appropriate interactions and relationships with residents on 3/4 by the PCHA.
5. All residents who have access and control of their own finances were interviewed on 3/4 by the business office manager to ensure this was an isolated incident. All residents reported that they feel safe and that no other residents had been approached.
6. A letter was sent to all residents on 3/4 by the PCHA reminding them of the homes Gifts & Tips policy.
7. The business office manager will survey all residents who have access to their own funds on a quarterly basis. This will begin in June '26 and be ongoing.

[Directed]

- *In addition to the steps above, the business office manager will survey all residents who have access to their own funds on a quarterly basis. These surveys will begin no later than 6/15/26. Documentation of these surveys will be kept and available for view by the Department.*

Directed Completion Date: *06/15/2026*

Implemented (- 06/16/2026)

42s - Privacy

3. 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

On 4/14/26, there were cameras in the activity room, library and lobby/sitting area. Staff Members C and D confirmed that this footage is recorded and can be reviewed as needed.

Plan of Correction ***Accept (- 05/27/2026)***

1. RCG states, "Video recording of the home's entrances and exits and the interior corridors leading to entrances and exits is permitted, provided that: 1. Residents are informed at admission that these areas are subject to video recording 2. Signs indicating that images are being recorded are posted in the areas that are being recorded. Both of these criteria were met for the Lobby, Activity, and Living Room, however, the department's position is that the angle is too wide.
2. Administration and Dir of Environmental Services were educated on the use of cameras on 5/13/26 by the PCHA.
3. The lobby exit camera's angle was adjusted by the Dir of Environmental Services on 5/12.
4. Recording was turned off for exits out of the Activity room and Living Room on 5/12. They are now only

42s - Privacy (continued)

monitoring (not recording). These are permanent adjustments, and the limited staff who have access to make changes have been educated.
5. IT will audit the camera angles on a quarterly basis, beginning 6/15/26. This will be on-going.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Implemented (- 06/16/2026)

81b - Resident Personal Equipment

4. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 4/14/26, the enabler bar on Resident #2's bed was not secured to the bed, sliding out from under the mattress with light pressure.

Plan of Correction ***Accept (- 05/18/2026)***

1. Resident's enabler bar was immediately secured on 4/14 by the Environmental Services Director.
2. All other enabler bars in use were immediately checked on 4/14 by the Environmental Services Director and found to be secured.
3. Wellness Department & Environmental Services were educated on this requirement on 5/4/26 by the PCHA and provided with a list of residents who utilize enabler bars.
4. Beginning June 1, housekeeping team will check the enabler bars monthly.

Licensee's Proposed Overall Completion Date: *06/01/2026*

Implemented (- 06/16/2026)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/14/26 at 10:45 PM, Resident #4's glucometer was used to check Resident #5's blood glucose level.

On 4/14/26 at approximately 9:45 AM, the bathroom located near the dining room had feces on and around the toilet seat. There was also toilet paper on the floor.

On 4/15/26 at approximately 9:30 AM, resident rooms #144 and #146 had a strong negative odor in rooms and several gnats were flying around the rooms.

85a - Sanitary Conditions (continued)

Plan of Correction ***Accept (- 05/18/2026)***

1. Upon discovery of the glucometers being switched, glucometers were replaced with new ones on 4/14.
2. Education for all Med Tech staff was provided on 5/11 by the Wellness Supervisor.
3. Beginning 5/22 bi-monthly glucometer audits will be done by the Med Techs. This will be a permanent on-going audit overseen by the Director of Wellness.
• Per DHS Supervisor, the examples of the bathroom and resident rooms has been withdrawn.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 06/16/2026)

85d - Trash Receptacles

6. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 4/14/26 at 9:10 AM, there was an overflowing, uncovered and unattended trash can located in the library.

On 4/14/26 at approximately 9:45 AM, there was an overflowing, uncovered and unattended trash can located in the bathroom, near the dining room.

Plan of Correction ***Accept (- 05/18/2026)***

1. Trash can was put in place on 5/12 by the Dir of Environmental Services Dir.
2. Environmental Services team was educated on the requirement of this regulation on 5/15 by the Dir of Environmental Services Dir.
3. By 5/22, an audit of all bathroom trashcans will be conducted to ensure that all trash cans have covers.
4. Beginning 5/22, the Dir of Environmental Services Dir will observe all trash cans in bathrooms on monthly audit to ensure covered trash cans are still in place. This is an on-going and permanent audit.
• Per DHS Supervisor, the example of the uncovered trash can in the library has been withdrawn.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 06/16/2026)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/15/26 at approximately 9:30 AM, resident room #144 had food on the floor, including a strawberry stem and chips.

88a - Surfaces (continued)

Plan of Correction ***Accept (- 05/18/2026)***

1. Room 144 had already been on a daily clean up schedule due to the resident preferring to snack all day every day. This room was cleaned by the housekeepers that day on 4/14.
2. Wellness & Environmental Services department were educated on the requirements of this regulation on 5/15 by the PCHA
3. Two additional lightweight sweepers will be delivered on 5/16 and strategically placed, so that any team member can sweep at any time.
4. Wellness Team members already do rounds at the change of each shift to ensure rooms are cleaned up.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 06/16/2026)

102k - No Common Towel

8. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

There was a used towel in Residents #2 and #3's shared bathroom. There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in this bathroom.

Plan of Correction ***Directed (- 05/27/2026)***

1. This towel was removed on 4/14 by housekeeping and each resident was given their own replacement towel.
2. Environmental Services and Wellness departments were educated on this requirement on 5/15 by the Environmental Services and Wellness Directors.
3. An audit of all towel bars in shared rooms was completed on 5/13 by the Environmental Services Director.
4. For shared rooms with two towel bars, labels with the resident names will be placed by the Environmental Services Dir. Shared rooms with only one towel bar—a second one will be installed. These will be complete by 5/22.
5. Beginning in 6/2026, shared rooms with towel bars will be checked by the Maintenance Director on a monthly basis. This will be an on-going audit.

[Directed]

- *In addition to the steps above, shared rooms with towel bars will be audited by the Maintenance Director on a monthly basis. These audits will begin no later than 6/15/26. Documentation of these audits will be kept and available for view by the Department.*

Directed Completion Date: *06/15/2026*

Implemented (- 06/16/2026)

103d - Storing Food Off Floor

9. Requirements

2600.
103.d. Food shall be stored off the floor.

103d - Storing Food Off Floor *(continued)*

Description of Violation

On 4/14/26 at 9:35 AM, a box of cooking oil was stored on the floor in the dry food storage closet.

Repeated Violation - 7/17/25 and 4/29/25, et al.

Plan of Correction ***Accept ([redacted] - 05/18/2026)***

1. The box containing unopened containers of cooking oil was immediately taken off the floor on 4/14 by the Dining Services Director.
2. All Dining Services team members will be educated on this requirement by 5/22 by the Dining Services Director.
3. Beginning on 5/5, a daily audit was put into place by the Dining Director and will continue until 5/22.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented ([redacted] - 06/16/2026)

132e - Fire Drill Sleeping Hours

10. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 9/26/25 at 11:30 PM. The previous sleeping hours fire drill was conducted on 3/16/25 at 10:05 PM.

Plan of Correction ***Accept ([redacted] - 05/18/2026)***

1. In this PCHA's 19 years as an administrator, the department has never interpreted this regulation to go by the exact day. There has never been communication to operators that this interpretation changed. DHS supervisor explained that is a new interpretation for the Central Regional office within the last year and that there is now a 5 day grace period.
2. Education on this NEW interpretation was provided to the Environmental Services Director on 5/13 by the PCHA.
3. PCHA already observes the fire drill logs on a monthly basis and will ensure adherence to this new interpretation. The next sleeping drill is due by May 26 2026

Licensee's Proposed Overall Completion Date: *05/26/2026*

Implemented ([redacted] - 06/16/2026)

183b - Meds and Syringes Locked

12. 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 4/14/26 at 9:15 AM, a white, oblong pill was on the floor of the hallway, located outside of Resident #7's room.

183b Meds and Syringes Locked (continued)

Repeated Violation 7/17/25.

Plan of Correction ***Accept (- 05/27/2026)***

1. This allergy pill was likely accidently dropped and not able to be found at that time. This pill was destroyed in the drug buster by the DOW on 4/14/26.
2. All team members were educated on this regulation by their department supervisors on 5/15
3. An audit of hallways by the administrative team began 5/5 and will end on 5/22, looking for loose pills.
4. Hallway floors are swept on a daily basis by housekeepers. This is permanent and on going.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 06/16/2026)

183d - Prescription Current

13. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 4/15/26, Ondansetron prescribed for Resident #7, was in the home's medication cart; however, this medication was discontinued on 2/9/26.

Repeated Violation 4/29/25, et al.

Plan of Correction ***Accept (- 05/18/2026)***

1. The Ondansetron was immediately removed on 4/15 by the Med Tech. The resident had not received any of the medication after the discontinue date.
2. All Med Techs were educated on this regulation by the department Supervisor on 5/8.
3. Pharmacy Consultant performs monthly med cart audits. This will continue.
4. Beginning 5/20 Med Techs will perform weekly audits on their med carts. This will be a permanent and on going audit overseen by the Director of Wellness.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 06/16/2026)

184a - Resident's Meds Labeled

15. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for Resident #5's Novolog pen did not include the sliding scale orders for this medication.

Plan of Correction ***Accept (- 05/18/2026)***

1. The pharmacy was contacted on 4/15 by the Med Tech Supervisor.
2. All Med Techs were educated on this issue on 5/5 by the Wellness Supervisor.

184a - Resident's Meds Labeled (continued)

3. Insulin bags will be audited on 5/21 and 5/22 by the Wellness Supervisor.
4. Night shift med tech will ensure that all insulin bags are properly labeled upon weekly delivery. This is a permanent audit and on-going.

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented ([redacted] - 06/16/2026)

185a - Implement Storage Procedures

16. 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

On 4/4/26 at 5:00 PM, Resident #5's glucometer had a blood sugar reading of 220. However, the documented reading in the resident's medication administration record was 98.

Resident #5 is prescribed Albuterol AER HFA, Cough Drop (LDR), and Ondansetron tab 4 MG as needed. On 4/15/26, these medications were not available in the home.

Resident #7 is prescribed Albuterol AER HFA and Preparation ointment as needed. On 4/15/26. these medications were not available in the home.

Repeated Violation - 7/17/25 and 4/29/25, et al.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

1. Upon discovery of the glucometers being switched, glucometers were replaced with new ones on 4/14.
2. Residents #5's cough drops were discontinued on 4/15 due to lack of use. Albuterol and Ondansetron were ordered on 4/15 and received on 4/15, however he has not needed them since 1/2026. A discontinue order will be requested on 5/15 by the Wellness Supervisor.
3. Resident #7 was also not in use of these PRN medications. They were reordered on 4/15 by the Med Tech and arrived on 4/15. A discontinue order will be requested on 5/15 by the Wellness Supervisor.
4. Education for all Med Tech staff was provided on 5/8 by the Wellness Supervisor.
5. Beginning 5/22 bi-monthly glucometer audits will be done by the Med Techs. This will be a permanent on-going audit overseen by the Director of Wellness.
6. Beginning 5/20 Med Techs will perform weekly audits on their med carts to ensure PRN meds are available. This will be a permanent and on-going audit overseen by the Director of Wellness

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented ([redacted] - 06/16/2026)