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

June 16, 2026

[redacted], COO
CARE HSL HERITAGE HILL OPCO LLC
[redacted]

RE: HERITAGE HILL SENIOR COMMUNITY
800 SIXTH STREET
WEATHERLY, PA, 18255
LICENSE/COC#: 22512

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/15/2026, 04/17/2026 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: *HERITAGE HILL SENIOR COMMUNITY* **License #**: *22512* **License Expiration**: *04/18/2026*

Address: *800 SIXTH STREET, WEATHERLY, PA 18255*

County: *CARBON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL HERITAGE HILL OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/05/2000* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *122* **Waking Staff**: *92*

Inspection Information

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

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

Inspection Dates and Department Representative

04/15/2026 - On-Site: [redacted]

04/17/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *42* **Residents Served**: *26*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*

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

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

04/15/2026 Full

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

06/01/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/03/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/03/2026*

Inspections / Reviews *(continued)*

06/16/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/03/2026*

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

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted] staff person A was heard saying, "Oh how I wish I could slap you right across the head," to Resident #1. Resident #1 was in front of staff person A, while this was being said.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action:
Immediately upon the report of a violation of resident rights having occurred, the accused employee was separated from residents, removed from the schedule, and suspended from duty pending an investigation. The Memory Care Director then followed the appropriate reporting procedures and provided a report to Carbon County Area Agency on Aging, along with the Department of Human Services. The family of the affected resident was also notified. The affected resident was monitored by the Memory Care Director throughout the remainder of the shift.

Additional Corrective Action:
As part of the investigative process, written statements were obtained. A representative from Carbon County Area Agency on Aging did visit the affected resident. Through the internal investigation process, the report of a resident rights violation was determined to be founded, and the employee was terminated from employment on [redacted]

Ongoing Corrective Action:
A mandatory nursing in-service was held by the Clinical Care Director on April 29, 2025, and included retraining on Resident Rights. Any complaints of resident rights violations will have immediate intervention and investigation. The Executive Director will meet with the Clinical Care Director regularly to monitor for compliance.

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

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

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person B, hired on [redacted] did not have a Pennsylvania State Police background check completed.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action
Immediately upon being notified that the Checkr platform utilized by Viva Senior Living is insufficient to comply with regulations related to Criminal Background Checks, a new Criminal Background Check was obtained via the E-PATCH system, which was returned with a satisfactory result. Management at Viva Senior Living was also notified that Checkr was not in compliance with regulations. Heritage Hill Senior Community will no longer utilize the Checkr platform.

51 - Criminal Background Check (continued)

Additional Corrective Action
On 4/15/2026, an audit of all new hires and rehires since the directive to use Checkr was completed to ensure that all files included compliant criminal background check. No additional deficiencies were noted.

Ongoing Corrective Action;
The Community will continue to utilize the E-PATCH platform to obtain criminal background checks for all newly hired employees and rehires. The onboarding documentation checklist will be updated and utilized to contain the positive affirmation that a compliant background check from the Pennsylvania State Police is completed prior to hire. The ED will monitor for compliance during regular 1:1 meetings with the Business Office Director.

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

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

89b - Hot Water Temperature

3. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At approximately 12:00 p.m. the water temperature measured 124.5 degrees Fahrenheit in the bathroom sink of Room #21.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action:
On discovery that a water temperature reading taken during inspection exceeded regulatory limits, the Maintenance Director investigated the source, and determined that a faulty probe was present. The probe was fixed immediately.

Additional Corrective Action
The Maintenance Director examined each boiler on site to verify functional probes were present on each, then sampled water temperatures throughout the building to verify that water coming from all boilers was heated to within regulation ranges.

Ongoing Corrective Action:
The Maintenance Director will complete a daily walkthrough checklist, which includes the verification of functional boiler probes and safe water temperatures. The Maintenance Director or Maintenance Assistant will call from service in a maintenance issue is found with any boiler. The Daily Walkthrough Checklist is provided to ED monthly, and ED will monitor for ongoing compliance.

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

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

91 - Telephone Numbers

4. Requirements

91 - Telephone Numbers *(continued)*

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the phone booth.

The telephone in the dining area does not have the required emergency telephone numbers posted.

Plan of Correction ***Accept (- 06/01/2026)***

Immediate Corrective Action:
The Business Office Associate immediately replaced the emergency phone number list on the phones that were found to be missing the required emergency numbers.

Additional Corrective Action:
Acrylic signage containing emergency numbers will be affixed permanently and conspicuously near each phone requiring such listing.

Ongoing Corrective Action:
The Daily Maintenance Walkthrough checklist will be updated to include the daily inspection of each phone for the presence of required emergency phone number postings. The checklist is provided monthly to the Executive Director, who will monitor for ongoing compliance.

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

Implemented (- 06/16/2026)

124 - Notice to Fire Department

5. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The notice to the fire department notes the home currently has 28 residents with mobility needs. The home currently serves 34 residents with mobility needs.

Plan of Correction ***Accept (- 06/01/2026)***

Immediate Corrective Action:
New Fire Letters will be sent to the required recipients on June 1, 2026. Mobility status will be defined and clearly outlined in the revised correspondence.

Additional Corrective Action:
An assessment of all residents will be completed no later than June 1, 2026 to determine mobility status as defined in the revised fire letters.

124 - Notice to Fire Department (continued)

Ongoing Corrective Action:
The revised Fire Letters will continue to be updated as required. The Executive Director will retain copies of such and monitor for continued compliance.

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

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

132h - Designated Meeting Place

6. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Resident interviews indicated that the residents are not always evacuated to the outside of the building during fire drills. If the weather is inclement the residents will stay in the lobby area or activity area of the building.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action: On April 16th, 2026. The Executive Director held an in-service for all managers and reviewed the compliance regulations regarding evacuation to a designated meeting place.

Additional Corrective Action:
The Maintenance Director will monitor weather forecasts to determine the safest day for each monthly fire drill to be held. All residents will be evacuated to the designated meeting place / fire safe area outside of the building.

Ongoing Corrective Action:
The Executive Director will retain copies of monthly fire drill logs and will monitor said logs for compliance with evacuation point regulations.

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

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

162c - Menus Posted

8. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 4/17/26 was posted. However, the meus for the following week were not posted.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action:
Menus were corrected and posted immediately upon the discovery that a full 2 week menu was not properly posted.

162c - Menus Posted (continued)

Additional Corrective Action:
The Food Service Director will complete a monthly department audit checklist, which includes the monitoring for compliant menu postings.

Ongoing Corrective Action:
On a monthly basis, the Food Service Director will provide the weekly Food Service Department checklist to the Executive Director, who will monitor for ongoing compliance.

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

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

181c - Self-administration Assessment

9. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #3 has a bottle of clobestasol propionate .005% in their room. The resident's medical evaluation dated 6/25/25 notes the resident is unable to self-administer medications.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action:
Immediately upon discovery of medications being found in a resident room, the medication was removed by the Clinical Care Director. On that same date, the family of the resident # 3 was notified by the Executive Director that medication should not be brought from home and given to the resident.

Additional Corrective Action:
All families will be provided with additional copies of home rules, which includes the prohibition of in-room medications without the completion of a self-administration assessment and documentation. This notice will be sent to families as an inclusion with their monthly invoicing in June 2026.

Ongoing Corrective Action:
Room checks throughout the building are completed as part of regular QA meetings and findings will be reviewed at each meeting.

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

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

185a - Implement Storage Procedures

10. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 4/7/26 at 7:16 a.m. Resident # 4's blood glucose was tested at 166. 168 was incorrectly recorded on the Medication Administration Record. On 4/12/26 at 8:04 a.m., the resident's blood glucose tested 114. 116 was incorrectly recorded on the Medication Administration Record.

Repeated violation 5/6/25

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action: All Med-Trained staff we in-serviced on April 29th, 2026 by Clinical Care Director on the regulations related to storage procedures.

Additional Corrective Action:
Med-techs are required to complete daily shift change checklists, which include the verification that Glucometer to MAR information is accurately documented. This checklist is submitted at the conclusion of each shift to the Clinical Care Director.

Ongoing Corrective Action:
The Clinical Care Director will monitor Shift Change Checklists are being completed daily for compliance. Disciplinary action will be taken for noncompliance. Findings and trends to be monitored during regular QA meetings.

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

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

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident # 5's albuterol HFA inhaler, inhale one puff four times daily is noted on the medication administration record and is not a current order.

Resident #6 had an order for Medihoney gel which was discontinued on 4/12/26. The medication was still listed as a current order on the residents April 2026 medication record.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action:
Immediately upon discovery, the Clinical Care Director contacted the Pharmacy to have the MAR updated to reflect current orders.

187a Medication Record (continued)

Additional Corrective Action:
The daily Shift Change checklist will be updated to include the verification that new orders received during that shift have been communicated and updated on the MAR.

Ongoing Corrective Action:
The Clinical Care Director will review daily shift change checklists for compliance. MAR to cart checks will be completed as assigned. Findings and trends will be reviewed during regular QA meetings

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

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

227d - Support Plan Medical/Dental

13. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #6 utilizes a bedside mobility device. The resident's assessment and support plan dated [redacted] does not indicate if the resident can safely use the device, any risks associated with the device, identification of the device used or if a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

Immediate Corrective Action:
RASP was updated on April 29th, 2026. RCD was in serviced on April 16th, 2026 by ED on on required documentation for use of mobility devices.

Additional Corrective Action:
The Resident Care Director will review the RASP of all residents with a bedside mobility device to audit for compliant documentation being present. Audit to be completed on or before June 1st, 2026.

Ongoing Corrective Action:
The Resident Care Director will complete quarterly audits of documentation for residents utilizing bedside mobility devices. RCD and ED will discuss audit results during 1:1 meeting. Compliance trends will be reviewed during regular QA meetings.

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

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