

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

June 16, 2026

[REDACTED] ADMINISTRATOR
WILLIAMSPORT AID II OPCO LLC
[REDACTED]

RE: LEIGHTON PLACE
1251 RURAL AVENUE
WILLIAMSPORT, PA, 17701
LICENSE/COC#: 22660

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/16/2026 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: LEIGHTON PLACE	License #: 22660	License Expiration: 05/15/2026
Address: 1251 RURAL AVENUE, WILLIAMSPORT, PA 17701		
County: LYCOMING	Region: NORTHEAST	

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

Legal Entity		
Name: WILLIAMSPORT AID II OPCO LLC		
Address: [REDACTED]		
Phone: [REDACTED]	Email: [REDACTED]	

Certificate(s) of Occupancy		
Type: C-2 LP	Date: 08/02/2002	Issued By: DLI

Staffing Hours		
Resident Support Staff: 0	Total Daily Staff: 49	Waking Staff: 37

Inspection Information		
Type: Full	Notice: Unannounced	BHA Docket #:
Reason: Renewal	Exit Conference Date: 04/16/2026	

Inspection Dates and Department Representative		
04/16/2026 - On-Site: [REDACTED]		

Resident Demographic Data as of Inspection Dates			
General Information			
License Capacity: 65		Residents Served: 36	
Secured Dementia Care Unit			
In Home: No	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: 3			
Number of Residents Who:			
Receive Supplemental Security Income: 0		Are 60 Years of Age or Older: 36	
Diagnosed with Mental Illness: 0		Diagnosed with Intellectual Disability: 0	
Have Mobility Need: 13		Have Physical Disability: 1	

Inspections / Reviews		
04/16/2026 Full		
Lead Inspector: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 05/17/2026
05/28/2026 - POC Submission		
Submitted By: [REDACTED]	Date Submitted: 06/10/2026	
Reviewer: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 06/04/2026

Inspections / Reviews *(continued)*

06/08/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/10/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/10/2026

06/16/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/10/2026

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

There was no carbon monoxide detector in the mechanical room, containing the natural gas hot water heaters. As per The Care Facility Carbon Monoxide Alarm Standards Act, there must be a carbon monoxide detector at least 15 feet from a fossil burning device.

Plan of Correction

Accept () - 05/28/2026

Immediate Action- replaced the CO2 detector immediately prior to exit

Training- Maintenance Director trained by the Executive Director on 4/16/2026 regarding regulation 18.

Ongoing- CO2 detectors audited for placement and working order each week for 4 weeks beginning on 4/27/2026, and then monthly beginning 6/1/2026 by the Maintenance director and/or designee via the TELS work system. This will be discussed during the Quarterly Quality management meetings.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

26b - Quality Management Plan Content

2. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

- 2. Complaint procedures.
- 3. Staff person training.
- 4. Licensing violations and plans of correction, if applicable.
- 5. Resident or family councils, or both, if applicable.

Description of Violation

The homes quality management meetings over the past year have not covered complaint procedures, staff person training, Licensing violations and plans of correction, or resident or family councils, or both.

Plan of Correction

Accept () - 05/28/2026

Immediate Action- Executive Director restructured the quality management plan to include both plan of correction and staff training.

Training- All management staff trained by the executive director on 4/23/2026 regarding regulation 26b and requirements of the new Quality Management Plan.

Ongoing- New Quality Management Plan was utilized on 4/23/2026 and management staff understood the requirements. Executive Director and/or designee will be responsible for making sure that the appropriate topics are discussed at each meeting quarterly beginning on 4/23/2026.

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

Implemented () - 06/16/2026

26b - Quality Management Plan Content (continued)

81b - Resident Personal Equipment

3. 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

Resident #7 has an enabler bar attached to their bed. At 10:15 a.m. the enabler bar was not covered. The bar has a gap of approximately 12 inches across.

Resident #8 has an enabler bar attached to their bed. At 1:20 p.m. the enabler bar was not covered. The bar has a gap of approximately 10 inches across.

Plan of Correction

Accept (█) - 05/28/2026

Immediate- Resident #7 and Resident #8's enabler bars were covered with a pillow case and secured. Appropriate cover purchased via Amazon.

Training- All caregivers, med techs and nurses trained on regulation 81b and requirements by Executive Director on 4/22/2026.

Ongoing- Medtechs will check resident enabler bars each shift and document whether safe and has a cover if indicated beginning 4/27/2026. If not safe will inform maintenance director or nursing director immediately for correction. Audits of documentation will be completed weekly for 4 weeks beginning on 5/4/2026. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented (█) - 06/16/2026

105g - Lint Removal and Duct Cleaning

4. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

The home has not cleaned the vents from the dryer to the outside of the building since 8/18/24.

Plan of Correction

Accept (█) - 05/28/2026

Immediate Action- Executive Director contacted cleaning provider on 4/16/2026 and cleaning completed on 4/21/2026 by Stanley Steemer.

Training- Maintenance Director trained on regulation 105g2 and requirements by Executive Director on 4/23/2026.

Ongoing- The dryer vent cleaning will be placed in the TELS work system as a task every 6 months and the

105g - Lint Removal and Duct Cleaning (continued)

maintenance director and/or designee will monitor for completion biannually. This will be discussed during the Quarterly Quality management meeting quarterly.

Licensee's Proposed Overall Completion Date: 05/08/2026

Implemented (█) - 06/16/2026)

132b - Safety Inspection/Fire Drill

5. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The homes most recent Fire Safety Inspection was completed on 3/4/25.

Plan of Correction

Accept (█) - 06/08/2026)

Immediate Action- Executive Director contacted the fire marshal to schedule the annual inspection and was completed on 5/22/2026.

Training- Maintenance Director trained by the Executive Director on 4/23/2026 regarding regulation 132b and requirements.

Ongoing- Fire marshal inspection requirement placed in the TELS work system to trigger a reminder for the maintenance director/and or designee to schedule the annual fire inspection and complete in the correct month.

Maintenance Director and/or designee will monitor for timely completion each year. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 06/30/2026

Implemented (█) - 06/16/2026)

132c - Fire Drill Records

6. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill held on 5/26/26 at 3:25 does not indicate if it occurred in the a.m. or p.m.

Plan of Correction

Accept (█) - 05/28/2026)

Immediate- Executive Director pulled the TELS records for the fire drill and it was completed on 2nd shift at 3:25 p.m. It wasn't pulled in time for the state to accept this information.

Training- Maintenance Director trained by the Executive Director on 4/17/2026 regarding regulation 132c and requirements.

Ongoing- Executive Director and Maintenance Director to audit the fire drill record each month for accuracy. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

132c - Fire Drill Records (continued)

Implemented () - 06/16/2026

141a 1-10 Medical Evaluation Information

7. 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. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #3’s initial medical evaluation signed on () did not include the date the evaluation was completed or the date the form was completed.

Plan of Correction

Accept () - 05/28/2026

Immediate- Resident #3’s new DME sent to provider for completion.

Training- Resident Wellness Director, Resident Care Coordinator, and Community Relations Director trained by the Executive Director on regulation 141a1 and requirements on 4/23/2026.

Ongoing- Audit of all resident DMEs for proper completion to be completed by 5/15/2026. Any discrepancies found will be sent to the PCP for correction. Audit of new and renewal DMEs will be completed by the Community Relations Director, Resident Wellness Director, and Executive Director prior to being placed in the chart. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

141b1 - Annual Medical Evaluation

8. Requirements

2600.

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

Description of Violation

Resident #4’s annual medical evaluation dated () does not indicate if the resident’s needs can be met in a personal care home.

141b1 - Annual Medical Evaluation (continued)

Plan of Correction

Accept () - 05/28/2026)

*Immediate- New DME sent to provider for Resident #4 for completion due to new hospice admission.**Training- Resident Wellness Director, Resident Care Coordinator, and Community Relations Director trained by the Executive Director on regulation 141a2 and requirements on 4/23/2026.**Ongoing- An audit of all current resident DMEs for appropriate completed by 5/15/2026. Any discrepancies found will be sent to the PCP for correction. This will be discussed during the Quarterly Quality management meeting.***Licensee's Proposed Overall Completion Date: 05/30/2026**

Implemented () - 06/16/2026)

162c - Menus Posted

9. 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 menu for the current week, 4/12/26 to 4/18/26 was not posted.***Plan of Correction**

Accept () - 05/28/2026)

*Immediate- The menu was hung on 4/16/2026 prior to exit.**Training- Dining Director trained by the Executive Director on 4/23/2026 regarding regulation 162c and requirements.**Ongoing- Menus being hung appropriately will be audited weekly for 4 weeks beginning on 4/27/2026 and then monthly for 2 months beginning on 6/1/2026 by the Executive Director and/or designee. This will be discussed during the Quarterly Quality management meeting.***Licensee's Proposed Overall Completion Date: 05/30/2026**

Implemented () - 06/16/2026)

184a - Resident's Meds Labeled

10. 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*Resident #1's Metoprolol Tartrate 25mg label is ripped off. The label is missing the prescribed dosage and instructions for administration.***Plan of Correction**

Accept () - 05/28/2026)

*Immediate- A new label placed on Resident #1's medication bottle on 4/16/2026.**Training- Med Techs, Resident Wellness Director and Resident Care Coordinator trained by Executive Director on 4/23/26 on regulation 184a and requirements.*

184a Resident's Meds Labeled (continued)

Ongoing Med Cart audits completed each week by the Resident Wellness Director and/or designee for 4 weeks starting on 4/27/2026. If any label missing or damaged it will be corrected immediately. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

187d - Follow Prescriber's Orders

11. Requirements

2600. 187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 has an order for blood glucose to be tested 4 times a day at 9:00 a.m., 12:00 p.m. 4:00 p.m. and at 8:00 p.m. with Novolog to be administered per a sliding scale at those times. On 4/8/26 and 4/10/26 at 12:00 p.m., the resident did not have their blood glucose tested or Novolog administered.

Plan of Correction

Accept () - 05/28/2026

Immediate Executive Director sent medication error report. Resident Wellness director called physician office and sent fax regarding medications and what should be done in the event the resident is out of the building. New order received.

Training Med Techs, Resident Wellness Director and Resident Care Coordinator trained by Executive Director on 4/23/26 on regulation 187d and requirements.

Ongoing Resident Wellness Director and/or designee will pull weekly missed med and exceptions report to assess any issues for 4 weeks beginning on 4/20/2026, then monthly for 2 months beginning on 6/1/2026. Any discrepancies will be addressed with the resident physicians and med techs. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

224a - Preadmission Screen Form

12. Requirements

2600. 224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3 was admitted to the home on () however the resident's preadmission screening form was completed on ()

Resident #5 was admitted to the home on () however the resident's preadmission screening form was completed on (). The form was also not signed by the person who completed the screening.

224a Preadmission Screen Form (continued)

Plan of Correction

Accept () - 05/28/2026

Immediate Resident #3, Resident #5, and Resident #7's prescreens evaluated for reason dated after admission.

Noted in their charts that it was found. Printed out the paper prescreen form for use moving forward.

Training Resident Wellness Director and Resident Care Coordinator trained by the Executive Director on 4/23/2026 on regulation 224a and requirements.

Ongoing Audit of all resident records for prescreens completed incorrectly and any done after move in will be identified by 5/15/2026. All move ins audited by the Executive Director and/or designee for completion and dates.

This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

225a - Assessment 15 Days

13. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident # 3's initial assessment dated () does not include that the resident uses a wheelchair for mobility.

Resident #7's assessment dated () did not include information about the resident's use of an enabler bar attached to their bed.

Plan of Correction

Accept () - 05/28/2026

Immediate Resident #3 had a more recent RASP completed, addendum to the RASP at the request of the state to reflect the mobility requirements including a wheelchair and 1 person assist transfers. Resident #7's RASP addended to include information regarding enabler bar use and requirements.

Training Resident Wellness Director and Resident Care Coordinator trained by the Executive Director on 4/23/2026 on regulation 225a and requirements.

Ongoing Audit of all resident RASPs completed by 5/15/2026 for appropriate dates, timely completion, and appropriate information. Any findings will be corrected with an updated RASP addendum. New admissions will be audited by Executive Director and/or designee prior to being placed in record for appropriate information. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

225c - Additional Assessment

14. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #6's most recent assessment was completed on [redacted] the previous one was completed on [redacted] The assessment dated [redacted] did not include information about the resident's use of an enabler bar.

Resident #3's and resident #5's assessments dated [redacted] were not updated to reflect that the residents utilize enabler bars that were installed on their beds on or around 4/13/26.

Repeated violation: 5/21/25 et al.

Plan of Correction

Accept ([redacted] - 05/28/2026)

Immediate- Resident #6, Resident #3, and Resident #5's RASPs addended to include the appropriate information regarding enabler and use.

Training- Resident Wellness Director and Resident Care Coordinator trained by the Executive Director on 4/23/2026 on regulation 225a and requirements.

Ongoing- All residents with enabler bars, RASPs audited by 5/15/2026 for completeness. If found to be incorrect will be addended with the correct information immediately. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

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

227g Support Plan Signatures

15. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3 and #5's support plan dated [redacted] was not signed by the person who completed the assessment.

Plan of Correction

Accept ([redacted] - 05/28/2026)

Immediate- Resident #3 and Resident #5's RASPs redone appropriately and signed by appropriate people to include the assessor, resident, and POA.

Training- Resident Wellness Director and Resident Care Coordinator trained by the Executive Director on 4/17/2026 on regulation 227h and requirements.

Ongoing- All resident RASPs audited for completed signatures by 5/15/2026. Any signatures missing will be obtained and all RASPs checked for completeness by the Resident Wellness Director and Executive Director and/or designee prior to being placed in charts. This will be discussed during the Quarterly Quality management meeting.

227g -Support Plan Signatures (continued)

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

227h - Support Plan Refuse Sign

16. Requirements

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #5's support plan dated [redacted] was not signed by the resident. The home did not note whether the resident refused to or was unable to sign the support plan.

Repeated violation: 7/16/25

Plan of Correction

Accept () - 05/28/2026

Immediate- Resident #3 and Resident #5 RASPs redone appropriately and signed by appropriate people to include the assessor, resident, and POA.

Training- Resident Wellness Director and Resident Care Coordinator trained by the Executive Director on 4/23/2026 on regulation 227h and requirements.

Ongoing- All resident RASPs audited for signatures by 5/15/2026. Any signatures missing will be obtained and all RASPs checked for completeness by the Resident Wellness Director and Executive Director and/or designees prior to being placed in charts. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026

Implemented () - 06/16/2026

251c - Standardized Forms

17. Requirements

2600.

251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #7's medical evaluation dated [redacted] was not completed using the Department's current standardized form.

Resident #3's medical evaluation dated [redacted] was not completed using the Department's current standardized form.

Resident #5's medical evaluation dated [redacted] was not completed using the Department's current standardized form.

Resident #4's medical evaluation dated [redacted] was completed on the form required for homes licensed under the 2800 regulations and not on the form required for homes licensed under the 2600 regulations.

251c - Standardized Forms (continued)

Plan of Correction**Accept (█ - 05/28/2026)**

Immediate- Correct DME for Resident #4 sent to the PCP for completion due to new hospice admission. Appropriate form given to Resident Wellness Director, Resident Care Coordinator, and Community Relations Director to utilize for new DMEs.

Training- Resident Wellness Director, Resident Care Coordinator, and Community Relations Director trained by Executive Director on 4/23/2026 on regulation 251c and requirement.

Ongoing- Audit of all resident DMEs completed by 5/15/2026 and any incorrect will be sent to the provider to be completed on correct form. Resident Wellness Director and Executive Director and/or designees will audit that the appropriate form is being used prior to admission. This will be discussed during the Quarterly Quality management meeting.

Licensee's Proposed Overall Completion Date: 05/30/2026**Implemented (█ - 06/16/2026)**