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

August 12, 2026

[redacted], BOARD PRESIDENT
SUGAR VALLEY LODGE INC
[redacted]

RE: SUGAR VALLEY LODGE
(WHISPERING PINES BUILDING)
178 SUGAR VALLEY LANE
FRANKLIN, PA, 16323
LICENSE/COC#: 44772

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/20/2026, 04/30/2026 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: *SUGAR VALLEY LODGE (WHISPERING PINES BUILDING)* **License #**: *44772* **License Expiration**: *07/30/2026*

Address: *178 SUGAR VALLEY LANE, FRANKLIN, PA 16323*

County: *VENANGO* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *SUGAR VALLEY LODGE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/20/2016* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/30/2026*

Inspection Dates and Department Representative

04/20/2026 - On-Site: [redacted]

04/30/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *15* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *6*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

04/20/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/06/2026*

06/18/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/28/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/23/2026*

Inspections / Reviews *(continued)*

06/30/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/28/2026*

08/12/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

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

20b1 - Financial Records

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

Resident #4 financial records are inconsistent: [redacted] 2026 SSI monthly deposit is [redacted], but the 1st quarter ledger reflects [redacted] (the 2025 SSI rate).

The 2026 monthly contract indicates $1,548.30, while the monthly ledger reflects $1,521.30.

Plan of Correction ***Accept ([redacted] - 06/18/2026)***

On 4/20/26 [redacted] COO identified the ledger error.
On 4/20/26 [redacted] COO worked with the Financial Manager [redacted] to get the amounts corrected.
By 6/15/26- [redacted] COO and [redacted] Financial Manager will audit the resident ledgers for accuracy. This will be completed quarterly by [redacted] CEO and [redacted] Financial Manager

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

Implemented ([redacted] - 08/12/2026)

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

Ancillary Staff member B was hired on [redacted] however, [redacted] Criminal Background check was not requested until [redacted]

Staff member C was hired on [redacted] however, the Criminal Background Check was not requested until [redacted]

Plan of Correction ***Accept ([redacted] - 06/18/2026)***

On 4/20/26 [redacted] COO identified that the background check was not done on the staff person listed above.
On 4/20/26- [redacted] COO did the background check for the staff person.
By 6/1/2026- [redacted] COO will have audited all staff charts to check for background checks. Before a staff person can be on the floor working, we now have to have the background check back. By 6/15/26-The background check will be added to the onboarding checklist. A new staff person can not be added to the schedule until we have the background check requested. This will be audited annually by [redacted] COO.

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

Implemented ([redacted] - 08/12/2026)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff member D did not receive annual training on meeting the needs of the residents as described in the preadmission screening form, assessment tool, med eval and support plan, Infection Control and Hygiene, Personal Care Service needs of the resident or care for residents with mental illness during the 2025 training year.

Staff E did not receive annual training in Infection control and hygiene, Personal Care needs of the resident or Care for a resident with Mental Illness during the 2025 training year.

Plan of Correction ***Accept ([redacted] - 06/30/2026)***

On 4/20/26 [redacted] COO Identified that the stated trainings were not included in the annual trainings.

On 6/3/26 [redacted] COO Created a plan that identifies each training needed annually they will be scheduled prior to the upcoming year tentatively.
By 7/1/26 All Trainings will be scheduled for the current year and upcoming year.

On 7/1/26 The above staff will be scheduled for a training on Preadmission screening forms, RASP and DME, Infection Control Training is scheduled for 11/25/26. A training on Mental Illness and IDD is tentatively scheduled for 11/5/26.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 08/12/2026)

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff member D did not receive annual training on Fire Safety, Emergency Preparedness, or Falls and Accident Prevention during the 2025 training year.

65g - Annual Training Content (continued)

Staff member E did not receive annual training on Emergency Preparedness, or the Older Adult Protective Services Act during the 2025 training year.

Plan of Correction ***Accept (- 06/30/2026)***

On 4/20/26 COO Identified that the stated trainings were not included in the annual trainings.
On 6/3/26 COO Created a plan that identifies each training needed annually they will be scheduled prior to the upcoming year tentatively.
By 7/1/26 All Trainings will be scheduled for the current year and upcoming year.

On 7/10/26 COO and CEO scheduled Rocky Grove Fire Department to be at Sugar Valley Lodge for the fire safety training. Emergency evacuation procedures is scheduled on 8/14/26. Accident and Falls Prevention is scheduled for 9/9/26. These are all Mandatory trainings if a staff member misses a training a training session will be offered to them.

Licensee's Proposed Overall Completion Date: *07/10/2026*

Implemented (- 08/12/2026)

66a - Staff Training Plan

5. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2026.

Plan of Correction ***Accept (- 06/30/2026)***

On 4/20/26 COO Identified that the stated trainings were not included in the annual trainings.
On 6/3/26 COO Created a plan that identifies each training needed annually they will be scheduled prior to the upcoming year tentatively.
By 7/1/26 All Trainings will be scheduled for the current year and upcoming year. COO and CEO have completed A roster with all staff names and positions as well as a list of trainings needed for each staff. Each month COO and CEO will audit the roster and make sure all staff have the attending the needed trainings. New staff will be added tot roster and the trainings that were missed will be added to their schedule. Each year starting Jan trainings will be scheduled for the following year. as to be ahead of the schedule.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented (- 08/12/2026)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 Lighting/Operable Lamp *(continued)*

Description of Violation

Resident #1 does not have access to a source of light that can be turned on/off at bedside. The lamp was unplugged.
Resident #2 does not have access to a source of light that can be turned on/off at bedside. The lamp was unplugged.
Resident #3 does not have access to a source of light that can be turned on/off at bedside. The lamp was unplugged.

Plan of Correction ***Accept (- 06/18/2026)***

On 4/20/26 [redacted] COO identified with rooms do not have the lamps plugged in.
On 4/21/26 [redacted] COO and [redacted] Medical Assistant created an audit sheet that has PCA/Med Techs, checking each light/lamp in every room to make sure it is plugged in, is in good working condition and is where it should be per regulations.
By 6/15/26 Every day 6a 2p and 2p 10p complete light checks and sign off in the ADL book that lights are working and in the correct place. Residents will sign an acknowledgement for for what items have to be in their rooms and where. Administrators [redacted] CEO, [redacted] COO and [redacted] Admin, Will add this to their admission packet as well as monthly quality checks.

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

Implemented (- 08/12/2026)

132b - Safety Inspection/Fire Drill

7. 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 home has not had a fire drill observed by a fire safety expert in the past 12 months.

Plan of Correction ***Accept (- 06/18/2026)***

On 4/20/26 [redacted] COO identified that the second page of the fire inspection form was not completed.
On 4/20/26 [redacted] COO located the second page of the form that needs signed by a fire safety expert and is available to every admin in each building.
By 6/15/26 [redacted] COO and [redacted] CEO, will have the correct papers needed for the fire expert training and documentation.

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

Implemented (- 08/12/2026)

141a 1-10 Medical Evaluation Information

8. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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 #2 was admitted on 02/24/26; however, a medical evaluation was not completed.

Plan of Correction ***Accept (- 06/18/2026)***

On 4/20/26 [redacted] COO identified that the DME for the stated resident was not completed
On 4/20/26 [redacted] COO worked with [redacted] Medical Assistant to complete the DME for the Resident.
BY 6/15/26- [redacted] COO and [redacted] will have created an audit form that makes sure when we admit a new resident the DME is completed within the timeframe.

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

Implemented (- 08/12/2026)

171b5 - First Aid Kit

9. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 4/20/26 at 10:46 AM there was no scissors, tweezers or breathing shield in the van's first aid kit.

Plan of Correction ***Accept (- 06/18/2026)***

On 4/20/26 [redacted] COO identified what was missing from the First Aid Kit in the van.
On 4/20/26 [redacted] COO worked with [redacted] Administrator to get what was needed for the van's first aid kit ordered and in the van.
By 6/15/26- [redacted] COO and [redacted] CEO will have created a pre-trip form that includes checking the first aid kit and making sure everything that has to be in it is. By 7/1/26 [redacted] COO and [redacted] will have completed a team meeting that acknowledges that anyone who drives the van how to complete the pre- trip form, what to do when something is not in the van that should be, and what happens if staff drive the van with the needed item are not included.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented (- 08/12/2026)

187c - Refusal of Medication

10. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #3 refused prescribed psychiatric medications, including Depakote, Haloperidol, Lithium Carbonate, and Gabapentin, from 2/19/26 through 3/9/26. All of these refusals were not reported to the prescriber.

Plan of Correction ***Accept (- 06/18/2026)***

On 4/20/26 [redacted] COO found the medication refusal forms that were completed for the stated resident.
On 4/20/26 [redacted] COO and [redacted] CEO created a staff meeting agenda that includes going over the procedure for medication refusals.
By 8/14/26 [redacted] COO and [redacted] will have a staff meeting/training on completing medication refusal forms/ procedures. In the interim [redacted] Medical Assistant will hold Med Tech meetings weekly to go over medication refusals for each building. Staff will sign an acknowledgment form identifying that they understand the procedure.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/12/2026)

225a - Assessment 15 Days

11. 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 #2 was admitted on [redacted]; however, a written initial assessment was not completed.

Plan of Correction ***Accept (- 06/30/2026)***

On 4/20/26 [redacted] COO identified that the stated resident did not have the assessment completed.
On 4/20/26 [redacted] COO and [redacted] Medical Assistant completed the assessment.
By7/1/26 [redacted] COO and [redacted] Medical Assistant will have audited all residents to make sure RASPs are completed on time and within regulation guidelines.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented (- 08/12/2026)

227a - Support Plan 30 Days

12. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

227a Support Plan 30 Days *(continued)*

Description of Violation

Resident #2 was admitted on [redacted] however, a written support plan was not developed and implemented within 30 days of admission to the home.

Plan of Correction ***Accept ([redacted] - 06/18/2026)***

On 4/20/26 [redacted] COO identified that the support plan for the stated resident was not completed.
On 4/20/26 [redacted] COO and [redacted] Medical Assistant completed the assessment.
By 7/1/26 [redacted] COO and [redacted] Medical Assistant will have audited all residents to make sure the RASP have been completed within the timeframe per regulations.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 08/12/2026)