





Pennsylvania  
Department of Human Services

Emailing Date: June 25, 2026



Nippenose Valley Village Inc.  
7190 South State Route, 44 Highway  
Williamsport, Pennsylvania 17702

RE: Nippenose Valley Village  
License #: 226700

Dear [REDACTED]:

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is an increase from 59 to 69 with 25 designated for SDCU. The expiration date of the license remains unchanged.

Any future requests for changes in capacity should be forwarded to the Department for review and consideration in accordance with the applicable regulations. The revised license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
License

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

June 23, 2026

[REDACTED]  
NIPPENOSE VALLEY VILLAGE INC  
7190 SOUTH STATE ROUTE 44 HWY  
WILLIAMSPORT, PA, 17701

RE: NIPPENOSE VALLEY VILLAGE  
7190 SOUTH STATE ROUTE 44 HWY  
WILLIAMSPORT, PA, 17701  
LICENSE/COC#: 22670

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/23/2026, 05/12/2026, 05/27/2026 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: NIPPENOSE VALLEY VILLAGE License #: 22670 License Expiration: 06/03/2026  
Address: 7190 SOUTH STATE ROUTE 44 HWY, WILLIAMSPORT, PA 17701  
County: LYCOMING Region: NORTHEAST

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: NIPPENOSE VALLEY VILLAGE INC  
Address: 7190 SOUTH STATE ROUTE 44 HWY, WILLIAMSPORT, PA, 17701  
Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: I-1 Date: 10/16/2025 Issued By: L & I  
Type: I-2 Date: 05/28/2026 Issued By: Central Keystone

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 51 Waking Staff: 38

**Inspection Information**

Type: Full Notice: Unannounced BHA Docket #:  
Reason: Renewal, Interim Exit Conference Date: 05/27/2026

**Inspection Dates and Department Representative**

04/23/2026 - On-Site: [REDACTED]  
05/12/2026 - On-Site: [REDACTED]  
05/27/2026 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information			
License Capacity:	59	Residents Served:	44
Secured Dementia Care Unit			
In Home:	No	Area:	N/A
Capacity:		Residents Served:	
Hospice			
Current Residents:	5		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	44
Diagnosed with Mental Illness:	0	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	7	Have Physical Disability:	0

**Inspections / Reviews**

**04/23/2026 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/12/2026

Inspections / Reviews *(continued)*

06/10/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/16/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/17/2026

06/16/2026 - POC Submission

Submitted: [REDACTED]

Date Submitted: 06/16/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 06/19/2026

06/23/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/16/2026

Reviewer: [REDACTED]

Follow-Up Type: Not Required

51 - Criminal Background Check

1. 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 A hired on [redacted]/25 did not have a Pennsylvania State Police criminal background check completed.

Plan of Correction

Accept [redacted] - 06/10/2026)

A background check has been completed on staff person A. Current staff member charts have been audited (see attached doc.). A background check has been completed on every staff member. Moving forward, a background check will be completed by the administrator or designee on applicants prior to their start date being given. An offer of employment will not be made until the background check has been completed, confirmed, printed. On the first day of employment, it will be placed in the staff member's file. Background checks will be discussed during weekly management meetings, ensuring compliance.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [redacted] - 06/23/2026)

95 - Furniture and Equipment

2. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At approximately 9:45 a.m., the bathroom wall in room #51 had an old emergency call box that did not have a face plate resulting in the wires being exposed.

At approximately 10:15 a.m., in the closet wall area of bedroom #49, an electrical socket box did not have a face place resulting in exposed wires.

Plan of Correction

Accept [redacted] - 06/10/2026)

Corrected on site - 5/12/26

Room #51 - A face plate was installed over the exposed wires (photo attached).

The new emergency call boxes are wireless and do not require hard wiring. The boxes are attached to the exterior of the wall. No further renovations to the emergency call boxes are planned therefore it is highly unlikely this situation will occur again.

Corrected on site - 5/12/26

Bedroom #49 - Electrical outlet was immediately installed in the box (photo attached).

No further renovations are planned in the SDCU, therefore, it is highly unlikely this situation will occur again.

If plans change and renovations are made anywhere in the home, the contractor will be directed to not allow any exposed electrical wires or electrical socket boxes before leaving the room due to the safety of the resident. The administrator will be involved in coordinating and monitoring all renovations during his daily walkthroughs. In addition, the attached Room Readiness sheet will be used to document and correct potential hazards prior to a resident's admission. This sheet will be utilized by the marketing/admissions director and the administrator or

95 - Furniture and Equipment (continued)

designee to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [REDACTED] - 06/23/2026)

107d - Procedure Emergency Management Agency Submission

3. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The facility did not submit their written annual emergency procedures to the local emergency management agency. The facility last submitted their annual emergency procedures to the local emergency management agency on 1/10/25.

Plan of Correction

Accept [REDACTED] - 06/10/2026)

Immediate action was taken by the administrator who requested a meeting with the Nippenose Valley Fire Chief to review the emergency preparedness plan. The plan was updated and submitted to the Fire Chief who reviewed, approved and signed the plan on May 13, 2026. The administrator has scheduled the next annual review with the Fire Chief to begin on April 26, 2027, allowing ample time for thorough review and updates, thereby ensuring compliance.

Licensee's Proposed Overall Completion Date: 06/09/2026

Implemented [REDACTED] - 06/23/2026)

132c - Fire Drill Records

4. 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 record for the drill conducted on 3/25/26 at 4:15 p.m. does not include the correct number of residents evacuated in the fire drill. Through interviews with staff, it was confirmed that Resident #4 did not evacuate. The fire drill log notes that 45 residents were in the home and 43 residents were evacuated.

Plan of Correction

Accept [REDACTED] - 06/16/2026)

All residents were evacuated during subsequent fire drills on 4/28/26, 5/29/26 and 6/4/26. Staff have been retrained on proper fire drill procedures, including the requirement that all residents must evacuate during the drill.

Immediately after each drill, the administrator will meet with the staff and review the details of the drill for accuracy - specifically the number of residents in the home at the time of the drill, the total number of residents evacuated, the number of participating staff and if there were any problems during the drill. After confirmation with the staff,

132c - Fire Drill Records (continued)

*the information will be recorded on the drill log. The administrator will also review the time it took for evacuation and discuss any needed corrective action.*

*Drills will be reviewed during monthly trainings.*

*The administrator serves as the fire safety expert of the home and will coordinate and monitor all fire drills in the home, ensuring compliance.*

**Licensee's Proposed Overall Completion Date: 06/12/2026**

**Implemented (redacted) 06/23/2026)**

132d - Evacuation

5. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

*During the fire drill on 11/26/25 at 10:00 am, the home's recorded evacuation time was 8 minutes and 9 seconds. The evacuation time for the home which was noted by a fire safety expert on 7/10/25 is 7 minutes and 30 seconds.*

*Repeated violation: 7/22/25*

Plan of Correction

**Accept (redacted) - 06/16/2026)**

*All fire drills conducted during in 2026 have been completed within the time determined by the Nippenose Valley Volunteer Fire Company Fire Chief. The acceptable time is reviewed with residents and staff after completion of each fire drill so that everyone is aware of the need to move with a purpose resulting in an acceptable evacuation time.*

*If a drill exceeds the amount of time determined by the fire safety expert, details of the drill will be discussed with staff during the post-drill meeting in order to determine the root cause of the failure to evacuate in the acceptable time. Corrective action including suggestions and recommendations will be discussed with staff and applied during the next drill. The unsuccessful drill will be documented on the fire drill record. Another unannounced drill will be held during the same month.*

*The administrator serves as the fire safety expert for the home and conducts all fire drills. He will ensure a successful fire drill is completed each month.*

**Licensee's Proposed Overall Completion Date: 06/12/2026**

**Implemented (redacted) - 06/23/2026)**

132g - Fire Drills Days/Times

6. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

*The fire drills conducted on 3/25/26 at 4:15 p.m., 2/20/26 at 1:30 p.m., 1/25/26 at 10:00 a.m., 8/26/25 at 4:00 p.m.,*

132g - Fire Drills Days/Times (continued)

1/20/26 at 1:30 p.m., 1/22/26 at 10:00 a.m., 12/29/25 at 3:00 p.m., 11/26/25 at 10:00 a.m., 10/23/25 at 5:30 a.m., 9/25/25 at 11:00 a.m. and on 8/26/25 at 4:00 p.m. were held on the 20th of the month or after. 10 of the 11 fire drills held were conducted exactly on the hour or at 30 minutes past the hour.

Plan of Correction

Accept [redacted] - 06/10/2026

Unannounced fire drills are being held at varying times, not exactly on the hour: 3/25/26 held at 4:15 pm; 4/28/26 held at 11:38 pm; 5/29/26 held at 2:35 pm; 6/9/26 held at 10:37 am.

Presently, the administrator serves as the fire safety expert and coordinates the fire drills.

The pattern of holding the drill after the 20th of the month has been broken with the drill on 6/9/26. The drills for the remainder of the year will be held at varying dates and times throughout the month, ensuring compliance.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [redacted] - 06/23/2026

132h - Designated Meeting Place

7. 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

During the fire drill on 3/25/26 at 4:15 p.m., Resident #4 did not evacuate to a designated meeting place away from the building or within the fire-safe area. Staff interviews confirmed the resident was not evacuated.

Plan of Correction

Accept [redacted] - 06/16/2026

Resident #4 didn't evacuate during the drill on 3/25 due to the misunderstanding that residents on hospice do not need to evacuate during drills. During inspection, the representative informed the administrator and resident care coordinator that hospice residents are required to evacuate the building. [redacted] explained there is a process (defined in the RCG) to go through in order to allow the hospice resident to remain in [redacted] room during a drill. The administrator and resident care coordinator educated staff on evacuating all residents, including those on hospice.

During the three subsequent fire drills, every resident was evacuated to a fire safe area. After the drills, the administrator discussed the timing and success of the drill with the residents and staff persons. Staff persons were reminded that all residents, including those on hospice are required to evacuate during drills.

To maintain ongoing compliance, all staff will work with the administrator in ensuring residents can evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. The administrator or designee will ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [redacted] - 06/23/2026

141b1 - Annual Medical Evaluation

8. Requirements

2600.

141b1 - Annual Medical Evaluation (continued)

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [REDACTED]/25. The resident's previous medical evaluation was completed on [REDACTED] 24.

Plan of Correction

Accept [REDACTED] - 06/10/2026)

Immediate action was taken- Resident #1's next annual evaluation has been scheduled to be completed on or before 11/24/26.

To maintain ongoing compliance the resident care coordinator created a chart listing the due dates of each resident's annual evaluation. The resident care coordinator brings this file to the weekly management meeting held at 10AM every Monday. Upcoming resident annual evaluations are discussed with the administrator and management team and confirmed on the resident care calendar. This process will enable the resident care coordinator to ensure each resident has a medical evaluation annually or sooner if there is a change in condition.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [REDACTED] - 06/23/2026)

182c - Medication Administration

9. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

- 7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 4/23/26 at 11:10 a.m., Staff person B administered medication to Resident #2. The staff member initialed the medication administration record prior to administering the medication to the resident.

Plan of Correction

Accept [REDACTED] - 06/16/2026)

Immediate action was taken by the resident care coordinator to reeducate staff person B on proper medication administration. The resident care coordinator explained that meds must be given prior to initialing the medication records. Staff person B acknowledged that she understood and would abide by the requirement. The resident care coordinator observed staff person B during her next medication pass to ensure compliance.

All medication technicians have been re-educated on the importance of proper medication administration, specifically the requirement to administer medications prior to initialing the medication record.

The resident care coordinator will begin observing medication technicians during med passes on 06/10/26.

Observations will be conducted weekly and randomly to ensure long term compliance. If discrepancies are found, the medication technician will be reeducated immediately. Observations will be documented in a log and reviewed with the administrator during weekly meetings.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [REDACTED] - 06/23/2026)

185a - Implement Storage Procedures

10. Requirements

185a - Implement Storage Procedures (continued)

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

The home's policy is that staff will count narcotics at each shift change and will sign a paper log sheet. On 4/22/26 at 11:00 p.m., the off going staff person did not sign the narcotics log sheet.

Plan of Correction

Accept [redacted] - 06/10/2026)

The requirement of signing off on the narcotics log sheet for the safety of our residents and staff members was reviewed as part of the monthly medication administration training (record of training attached).

The lead med techs on each shift will count narcotics together and then confirm the signature by the off going med tech. Each shift will follow this protocol. A med tech will not be permitted to leave until the signature is confirmed.

The sign off sheet is being monitored by the resident care coordinator to ensure compliance.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [redacted] - 06/23/2026)

187d - Follow Prescriber's Orders

11. Requirements

2600.

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

Description of Violation

Resident #5 is prescribed Insulin Lispro that is to be administered 3 times daily at 8:00 a.m., 12:00 p.m. and 5:00 p.m. However, this medication was not administered to the resident on 4/23/26 at 7:00 a.m. and 11:00 a.m. because the medication was not available in the home.

Plan of Correction

Accept [redacted] - 06/16/2026)

This was an issue with insurance not covering Lispro and a breakdown in communication between the primary care physician and the pharmacy.

Immediate action was taken to secure Insulin medication Fiasp.

The resident care coordinator speaks to the pharmacy daily regarding medication orders and changes to orders. The resident care coordinator reeducated staff on the importance of timely reordering of medications and clear communication with physicians and the pharmacy, ensuring we are following directions of the prescriber.

In order to maintain long-term compliance, the resident care coordinator began weekly medication cart audits on 06/09/26 to ensure all medications ordered by the prescriber are on the med cart (audit attached). The resident care coordinator will share her findings during the weekly management meeting with the administrator.

Licensee's Proposed Overall Completion Date: 06/12/2026

Implemented [redacted] - 06/23/2026)

233c - Key-Locking Devices

12. Requirements

2600.

**233c - Key-Locking Devices (continued)**

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**Description of Violation**

*At approximately 10:10 a.m. the foyer area of the secured dementia care unit did not have directions for the operation of the key locking device posted.*

*At approximately 10:10 a.m. the secure dementia care unit emergency exit gate did not have directions for the operation of the key locking device posted.*

**Plan of Correction**

**Accept** [REDACTED] - 06/10/2026)

*Corrected on site - 5/12/26*

*Directions for the operation of the key locking device have been posted in the foyer area and the emergency exit gate (photos attached). In the event that the directions are removed or found to be missing, the directions will be reposted by a member of the management team. Extra copies of the directions are kept in the administrative office by the lobby and are accessible to all staff members. The administrator will monitor for ongoing compliance during daily walk-throughs.*

**Licensee's Proposed Overall Completion Date: 06/09/2026**

**Implemented** [REDACTED] - 06/23/2026)

**251c - Standardized Forms**

**13. Requirements**

2600.

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

**Description of Violation**

*Resident #3's medical evaluation dated [REDACTED]/26 was not completed on the Department's current standardized form.*

**Plan of Correction**

**Accept** [REDACTED] - 06/10/2026)

*Immediate action was taken by having a new medical evaluation completed using the Department's standardized form - Documentation of Medical Evaluation (DME).*

*The resident care coordinator has been reeducated on the importance of using the standardized form for medical evaluations.*

*Resident charts have been audited for use of standardized forms.*

*The correct form is being used on all current and incoming resident's medical evaluations. The resident care coordinator and administrator will work together during the admission process to ensure correct form compliance.*

**Licensee's Proposed Overall Completion Date: 06/12/2026**

**Implemented** [REDACTED] - 06/23/2026)