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

August 4, 2026

[redacted], PRESIDENT
WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC
7990 US ROUTE 30
NORTH HUNTINGDON, PA, 15642

RE: THE NEIGHBORHOODS AT
WALDEN'S VIEW
7990 US ROUTE 30
NORTH HUNTINGDON, PA, 15642
LICENSE/COC#: 44681

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/23/2026, 04/24/2026, 04/29/2026 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: *THE NEIGHBORHOODS AT WALDEN'S VIEW* **License #**: *44681* **License Expiration**: *05/21/2027*

Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA 15642*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC*

Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA, 15642*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/19/2015* **Issued By**: *N Huntingdon Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *04/29/2026*

Inspection Dates and Department Representative

04/23/2026 - On-Site: [redacted]
04/24/2026 - Off-Site: [redacted]
04/29/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Whole Building* **Capacity**: *40* **Residents Served**: *37*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *37* **Have Physical Disability**: *0*

Inspections / Reviews

04/23/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/30/2026*

Inspections / Reviews *(continued)*

06/16/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

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

07/16/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/21/2026*

08/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

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

65f - Training Topics

3. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
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.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A and direct care staff person C did not receive training in medication self-administration during the January 1, 2025 to December 31, 2025 training year.

Direct care staff person C did not receive training in the following topics during the January 1, 2025 to December 31, 2025 training year:

* *Instruction on meeting the needs (DME & RASP)*
* *Care for residents w/dementia & cognitive impair.*
* *Infection control/cleanliness/immobility concerns*
* *Personal care service needs of the resident*
* *Safe management techniques*
* *Care for residents with MH or ID, if served*

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on required annual training topics that were not fully completed for Staff Person A and Staff Person C during the January 1, 2025 through December 31, 2025 training year.
Staff Person C completed training on medication self-administration on 4/27/2026 by RCC. Documentation will be kept. Staff person A was unable to complete training due to being terminated from Waldens View due to the outcome of BHSL investigation.
Staff Person C completed training in the following required topics: Instruction on meeting resident needs, including DME and RASP. Care for residents with dementia and cognitive impairments. Infection control, cleanliness, hygiene, and immobility concerns. Personal care service needs of residents. Safe management techniques. Care for residents with mental illness and/or intellectual disabilities on 4/27/2026 by RCC. Documentation will be kept.
All direct care staff training records were audited to verify completion of annual training topics required on 4/28/2026 by Compliance Director. Documentation was kept.
Administration and supervisory staff will be educated on requirements for annual staff training compliance on 5/18/2026 by Compliance Director. Documentation will be kept.
A designated staff member will monitor training completion monthly to ensure all required topics all required staff are completed within the training year starting 6/1/2026. Documentation will be kept.
The Administrator/designee will: Review staff training records monthly for compliance. Maintain a current training log for all direct care staff starting 6/1/2026. Any deficiencies identified will be corrected immediately through staff

65f Training Topics (continued)

re education and following up at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

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:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff person C did not receive training in emergency preparedness procedures during the January 1, 2025 to December 31, 2025 training year.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken with Staff Person C not complete annual training in emergency preparedness procedures during the January 1, 2025 through December 31, 2025 training year.
The following corrective actions have been implemented: Staff Person C completed training on emergency preparedness procedures, including recognition and response to crises and emergency situations on 4/27/2026 by RCC. Documentation will be kept.
Administration and supervisory staff were educated on monitoring annual training compliance to prevent missed training requirements on 5/18/2026 by compliance director. Documentation will be kept.
The Administrator/designee will: Conduct monthly reviews of staff training records starting on 6/1/2026. Maintain ongoing tracking of required annual training topics. Any missing or incomplete training identified will be corrected immediately through re education and follow up at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

81b - Resident Personal Equipment

5. 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

The enabler bar attached to resident #1's bed was not secured, moving approximately 2 inches to 3 inches from head to toe when grabbed, posing an entrapment hazard.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on the bed cane attached to Resident #1's bed.

81b Resident Personal Equipment (continued)

The following corrective actions have been implemented: On 4/23/2026 while inspector was on site, the bed cane was immediately further secured and adjusted. Resident #1's bed and equipment were inspected to ensure safety and proper function by maintenance director and admin.
A full inspection of resident beds, assistive devices, and related equipment was conducted throughout the facility to identify and correct any additional hazards on 4/24/2026 by maintenance. Documentation will be kept.
Staff were re educated on identifying and reporting unsafe equipment and environmental hazards immediately on 5/18/2026.
The Administrator/designee will: Conduct weekly environmental and equipment safety rounds for 30 days and monthly thereafter starting 6/1/2026.
Any issues identified will be corrected immediately through repair, replacement, and staff re education as needed and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

82a - Poisonous Materials

6. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

There were two plastic spray bottles in the dry storage area with a handwritten label that indicated, "Auto ODO BAN Bugs Flea Spray."

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on the unmarked spray bottle. It was removed from the kitchen immediately upon discovery by maintenance. The contents were safely disposed of.
On 5/18/2026 all staff received refresher training by admin/designee on
chemical safety, including requirement that all poisonous or cleaning materials must remain in original manufacturer labeled containers. Prohibition on transferring chemicals into secondary/unlabeled containers.
Starting 6/1/2026 the admin/designee will conduct random weekly audits for 60 days and biweekly thereafter to ensure compliance with chemical storage requirements. Any noncompliance will be addressed immediately with corrective coaching and discussed at the quality management meeting on 6/10/2026.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

82b - Poisonous Material Storage

7. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

There were multiple cleaning products and poisonous materials stored on a shelf in the dry storage area next to the

82b - Poisonous Material Storage (continued)

canned food storage rack and emergency food, to include the following:
One 28-ounce container of CLR cleaner, with a manufacture's label that indicated, "If swallowed contact poison control center or doctor."
One 18-ounce aerosol spray can of Pro Power oven and grill cleaner, with a manufacture's label that indicated, "If swallowed contact poison control center or doctor."
One 1-quart bottle of Spic and Span cleaner, with a manufacture's label that indicated, "If swallowed contact poison control center or doctor."

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken with the cleaning products and poisonous materials that were improperly stored in the dry storage area near canned food and emergency food supplies by maintenance director.
The following corrective actions have been implemented: All cleaning products and poisonous materials were immediately removed from the dry food storage area. Cleaning chemicals were relocated to a designated secured storage area separate from food, food preparation surfaces, and dining surfaces. The dry storage area was inspected to ensure no additional hazardous materials remained near food supplies. This was completed on 4/24/2026 by maintenance director. Documentation will be kept.
Staff were re-educated on proper storage requirements for cleaning chemicals and poisonous materials on 5/18/2026 by admin/compliance director. Documentation will be kept.
Starting on 6/1/2026, the Administrator/designee will: Conduct weekly inspections of food storage and chemical storage areas for 30 days and biweekly thereafter. Monitor staff compliance with proper storage procedures. Review environmental safety concerns during routine rounds. Documentation will be kept.
Any deficiencies identified will be corrected immediately through removal of hazardous materials and staff re-education as needed and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

85a - Sanitary Conditions

8. Requirements

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

Description of Violation

On 4/23/26 at approximately 10:00 a.m., there was an approximate 6 inch by 6 inch a puddle of tea, several onion skins and dirt/grime on the floor of the walk-in cooler.
Also, there were multiple food crumbs, and dirt/grime caked into the non-skid floor mat on the floor of the walk-in freezer.

REPEATED VIOLATION - 4/9/25

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken with the walk-in cooler and walk-in freezer, including spilled liquid, food debris, and dirt/grime accumulation.
The following corrective actions have been implemented: The walk-in cooler and walk-in freezer were immediately cleaned and sanitized, including floors and non-skid mats on 4/30/2026 by maintenance. Documentation was kept.
All staff were re-educated on sanitation expectations, cleaning schedules, and maintaining clean food storage areas on 5/18/2026 by admin/compliance director.
The Administrator/designee will: Conduct weekly sanitation audits of dietary storage areas for 30 days and biweekly thereafter starting 6/1/2026. Documentation will be kept.
Any deficiencies identified will be corrected immediately through cleaning and staff re-education as needed and discussed in the 6/10/2026 quality management meeting. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

87 - Lighting

9. Requirements

2600.
87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The light bulbs and fixtures of the fluorescent lights in the Victorian Way shower room were removed, exposing wires and were inoperable.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on fluorescent light fixtures in the Victorian shower room that were inoperable and had exposed wiring due to removed bulbs and fixtures. Victorian shower room was under construction, no resident can access the Victorian shower room without a code, the home has three other working shower rooms that staff were aware of utilizing during construction. Lighting fixtures were ordered on 4/19/2026 and delivered on 4/23/2026.
The home respectfully requests 87 be removed due to general maintenance of the home and having three other operational showers.
The following corrective actions have been implemented: The shower room lighting issue was immediately reported to maintenance. The breaker was turned off in Victorian shower room to eliminate any potential safety hazard by maintenance director.
The light fixtures and bulbs were repaired/replaced, and lighting was restored to proper working condition 4/24/2026 by maintenance director.
Maintenance staff were re-educated on timely repair of environmental and safety concerns 5/18/2026 by admin/compliance director. Documentation will be kept.
The facility conducted an inspection of all resident care areas to identify and correct any additional lighting or electrical concerns 4/24/2026 by maintenance team.
The Administrator/designee will: Conduct weekly environmental rounds for 30 days and biweekly thereafter to monitor lighting and electrical safety starting 6/1/2026. Documentation will be kept.

87 - Lighting (continued)

Address any identified deficiencies immediately and discuss in the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

88a - Surfaces

10. 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

There was approximate 4 foot by 4 foot area with peeled/missing paint and brownish gray colored water damage on the wall behind the food racks in the dry storage area.

REPEATED VIOLATION - 4/9/25

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on the area of peeled/missing paint and water damage that was identified on the wall behind the food racks in the dry storage area.
The following corrective actions have been implemented: The affected area was inspected to identify the source of the water damage. Repairs were completed to address and eliminate the cause of the moisture/water intrusion. Damaged wall surfaces were repaired, cleaned, and repainted to restore the area to good condition on 4/28/2026 by maintenance director. Documentation can be provided.
The dry storage area was inspected for additional maintenance or environmental concerns by maintenance director. Maintenance and supervisory staff were re-educated on identifying and promptly addressing environmental repair issues on 5/18/2026 by admin/compliance director. Documentation will be kept.
The Administrator/designee will: Conduct weekly environmental rounds for 30 days and biweekly thereafter starting 6/1/2026. Documentation will be kept.
Any deficiencies identified will be corrected immediately through repair and staff follow-up and discussed at the quality management meeting 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

101j2 - Bedroom Chairs

12. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom #207 was occupied by two residents; however, there were no chairs in this bedroom.

101j2 Bedroom Chairs *(continued)*

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken in Bedroom #207, occupied by two residents, that did not have the required chairs available in the room. The maintenance director placed a chair under each bed in room 207 in the memory care unit while BHSL was onsite on 4/23/2026.

The following corrective actions have been implemented: All resident bedrooms were inspected to ensure required furnishings are present, including chairs for each resident on 4/24/2026 by maintenance team/housekeeping. Maintenance and housekeeping staff were instructed to report missing or damaged furniture immediately to Admin/RCC.

The Administrator/designee will: Conduct weekly room audits for 30 days and biweekly thereafter to ensure all required bedroom furnishings are present starting 6/1/2026 Documentation will be kept. Address any deficiencies immediately upon identification and discuss during quality management on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

101j7 - Lighting/Operable Lamp

13. 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.

Description of Violation

Resident #2 does not have access to a source of light that can be turned on/off at bedside. The lamp on the bedside table did not have a lightbulb.

Resident #3 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken with Resident #2 and Resident #3 who did not have access to an operable bedside lighting source as required.

The following corrective actions have been implemented: Resident #2's bedside lamp was immediately supplied with a working lightbulb to ensure operable lighting by maintenance staff. Resident #3 was provided with an operable bedside lamp/lighting source by maintenance team. This was all completed while inspector was on site. All resident rooms were inspected to verify that each resident has access to working bedside lighting on 4/24/2026 by maintenance director. Maintenance and housekeeping staff were instructed to immediately report missing bulbs, damaged lamps, or lighting deficiencies by the RCC.

The Administrator/designee will: Conduct weekly bedroom safety and equipment audits for 30 days biweekly thereafter. Verify operability of bedside lighting during routine room checks starting 6/1/2026. Documentation will be kept. Ensure deficiencies are corrected immediately upon identification and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

101j7 Lighting/Operable Lamp *(continued)*

Implemented ([redacted] - 08/04/2026)

103f Refrigerator/Freezer Temps

14. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/23/26 at 10:31 a.m., the temperature in the walk-in freezer was 5 degrees Fahrenheit and at 3:00 p.m., it was 10 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

The facility acknowledges the documented temperature readings of the walk-in freezer on April 23, 2026, which were recorded at 5°F at 10:31 a.m. and 10°F at 3:00 p.m.
The facility respectfully disagrees with this violation and ask that it be removed. The facility would like to clarify that these temperature fluctuations were temporary and operational in nature, occurring during active meal preparation periods for lunch and dinner. During these times, staff were required to frequently enter and exit the walk-in freezer, which can result in brief increases in internal temperature readings.
These fluctuations are consistent with normal usage patterns of walk-in freezer units during high-traffic meal service periods and do not necessarily indicate a malfunction or sustained inability of the unit to maintain safe temperature ranges.
To ensure the proper functioning of the equipment, Fugh Refrigeration was contacted on 4/23/2026 and came out to inspected the walk-in freezer on May 5, 2026. At the time of inspection, the unit was found to be operating appropriately with no identified mechanical issues or deficiencies. Documentation was kept.
This confirms that the freezer was maintaining proper working condition, and the temperature variations observed were not indicative of equipment failure but rather consistent with operational use.
All staff were educated on 5/18/2026 on proper temps for freezers and coolers by admin/compliance director.
Dietary staff will continue to monitor and document freezer temps 2x's daily and report any concerns to admin/management. Documentation will be kept.
Ensure deficiencies are corrected immediately upon identification and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

103g Storing Food

15. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There were 29 unpackaged small cookies on the desk in resident #4's bedroom.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate

103g - Storing Food (continued)

action was taken on the unpackaged cookies that were found in Resident #4's bedroom and were not stored in a closed or sealed container by being removed and thrown away by maintenance director.
The following corrective actions have been implemented: Staff were re-educated on proper food storage requirements, including the need to keep all food in sealed or closed containers on 5/18/20206 b y admin/compliance director. Documentation will be kept. Staff were reminded that food items must be properly stored to prevent contamination and pest attraction.
The Administrator/designee will: Conduct weekly resident room audits for 30 days and biweekly thereafter to ensure proper food storage practices starting 6/1/2026. Documentation will be kept. Address any deficiencies immediately through re-education and corrective action and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

105g - Lint Removal and Duct Cleaning

16. 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

There was an approximate 1/8-inch accumulation of lint coating the back of the two industrial dryers and on the electrical wires and ductwork in the laundry room.

REPEATED VIOLATION - 4/9/25

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on the lint accumulation that was found on the back of the industrial dryers, electrical wires, and ductwork in the laundry room by maintenance while BHSL was on site.
The home would like to clarify that the lint traps and ventilation were all clean and 1/8" accumulation of lint and dust is not accurate based on photo evidence. The home respectfully request 105g to be withdrawn and request the note that this is repeat be removed as prior instance was greater than 1 year.
The following corrective actions have been implemented: The laundry room dryers, including surrounding areas, ductwork, and electrical components, were thoroughly cleaned to remove all visible lint accumulation by maintenance team. The staff were re-educated on the requirement to remove lint after each use and maintain a lint-free environment on 5/18/2026 by admin/compliance director. Documentation will be kept.
The Administrator/designee will: Starting 6/1/2026 staff will Conduct daily laundry room inspections for 30 days and weekly for 30 day and then biweekly thereafter. Verify completion of lint trap cleaning logs after each use. Monitor duct and surrounding area cleanliness during environmental rounds. Documentation will be kept. Provide corrective re-education immediately if deficiencies are identified and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

105g - Lint Removal and Duct Cleaning *(continued)*

Implemented ([redacted] - 08/04/2026)

185a - Implement Storage Procedures

17. 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

Resident #1's glucometer was not set to the correct date and time. The glucometer indicated 4/21/26 and 8:23 p.m. However, the actual date and time was 4/23/26 and 3:08 p.m.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

The facility acknowledges the observation that Resident #1's glucometer displayed an incorrect date and time at the time of review.
The facility would like to clarify that the glucometer in question was associated with a PRN (as-needed) physician's order and had not been actively used for monitoring prior to the observation. As a result, the device did not require calibration or adjustment at that time.
Facility protocol is to verify and calibrate equipment at the time of use to ensure accuracy of readings. Had the glucometer been needed for resident care, staff would have appropriately confirmed and adjusted the date and time settings prior to obtaining any blood glucose measurements.
The home request 185a to be withdrawn since the facility followed proper protocols and no calibration was needed since the device was not in use. Had the glucometer been needed it would have been calibrated at that time.
In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on Resident #1's glucometer that was found to have an incorrect date and time setting. Admin/LPN obtained an order to have the glucometer discontinued due to never being used on 4/23/2026. Documentation was kept.
The following corrective actions have been implemented: RCC responsible for medication administration and glucose monitoring were re-educated on proper glucometer setup, including verifying date and time prior to use by compliance director. Documentation will be kept.
The Administrator/designee will: Conduct weekly audits of resident glucometers and other medical devices for 30 days and monthly thereafter. Verify staff compliance with equipment checks prior to use starting 6/1/2026. Address any deficiencies immediately through re-education and corrective action and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

233c - Key-Locking Devices

18. Requirements

2600.
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

The directions for operating the home's locking mechanism were not conspicuously posted near the exit door between

233c - Key-Locking Devices (continued)

the elevator and medication room, on the 2nd floor of the Secured Dementia Care Unit (SDCU).

REPEATED VIOLATION - 4/9/25

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

The facility respectfully disputes the statement that directions for the home's locking mechanism were not conspicuously posted near the exit door between the elevator and medication room on the second floor of the Secured Dementia Care Unit (SDCU).
At the time of observation, the required instructions were in fact posted in conspicuous location near the exit door above the door, in accordance with regulatory requirements. The location of the code has been the same for over a decade, since we first corrected the violation cited in 2015-2016 by adjusting the code and posting procedures to meet this exact criteria at that time.
It is the facility's position that the issue was not the absence of posted instructions, but rather a possible misinterpretation or difficulty in recognizing the instructions as displayed.
Therefore, the deficiency as written inaccurately reflects the conditions present at the time of the survey, and the facility respectfully requests that this finding be reviewed and amended to reflect that the instructions were appropriately posted.
In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on posted directions for the operation of the key-locking mechanism that BSHL felt was not conspicuously displayed at the exit door between the elevator and medication room on the 2nd floor of the Secured Dementia Care Unit (SDCU). Clear, conspicuous instructions for operating the key-locking device were immediately posted at the identified exit door on 5/1/2026 by admin/maintenance director. Documentation was kept.
The following corrective actions have been implemented: Staff were re-educated on the importance of ensuring all key-locking device instructions remain visible, accurate, and properly maintained by admin/compliance director. Documentation will be kept.
The Administrator/designee will: Conduct weekly audits of all secured unit exits for 30 days. Verify that all key-locking device instructions remain posted and legible starting on 6/1/2026. Documentation will be kept. Address any missing or unclear postings immediately upon identification and discuss at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)

234b - Support Plan Needs Elements

19. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated 10/7/25, for resident #2 does not address the significant wound care for the resident.

Plan of Correction ***Accept ([redacted] - 06/16/2026)***

In response to the violation on 4/23/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on that Resident #2's support plan, dated [redacted] that did not include the resident's significant wound care needs on 4/24/2026 by RCC and MD.
The following corrective actions have been implemented: Resident #2's support plan was immediately reviewed

234b - Support Plan Needs Elements (continued)

and updated to include current wound care needs, treatment regimen, and monitoring requirements on 4/24/20206 by RCC and confirmed by compliance director. Documentation will be kept.
The wound care information was verified against current physician orders and nursing documentation for accuracy and consistency. All staff were re-educated on the requirement to ensure all active medical conditions, including wound care, are fully reflected in the support plan on 5/18/2026 by compliance director. Documentation will be kept.
All current resident support plans were reviewed to identify and correct any additional omissions related to medical or physical needs by compliance director by 6/1/2026. Documentation will be kept.
The Administrator/designee will check any updated support plans completed by RCC to verify that all current medical conditions and treatments are accurately reflected in each resident's support plan. Documentation will be kept. Ensure updates are completed promptly when a resident's condition changes. This will begin 6/1/2026. Documentation will be kept.
Address any deficiencies immediately through re-education and corrective action and discussed at the quality management meeting on 6/10/2026. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 08/04/2026)