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

June 30, 2026

[redacted], EXECUTIVE VICE PRESIDENT
2101 WABANK ROAD OPERATING COMPANY LLC
[redacted]

RE: OAK LEAF MANOR PERSONAL CARE
RETIREMENT HOME
2101 WABANK ROAD
MILLERSVILLE, PA, 17551
LICENSE/COC#: 33820

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/05/2026 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: *OAK LEAF MANOR PERSONAL CARE RETIREMENT HOME* **License #**: *33820* **License Expiration**: *11/21/2026*

Address: *2101 WABANK ROAD, MILLERSVILLE, PA 17551*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *2101 WABANK ROAD OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/22/2010* **Issued By**: *L&I*

Type: *I-2* **Date**: *01/10/2014* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *82* **Waking Staff**: *62*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *05/06/2026*

Inspection Dates and Department Representative

05/05/2026 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *82* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Friendship Place* **Capacity**: *43* **Residents Served**: *22*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *59*

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

Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

05/05/2026 Full

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

Inspections / Reviews *(continued)*

06/01/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/29/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/05/2026*

06/01/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/29/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/29/2026*

06/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/29/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 1/30/26, Staff Member A observed Resident #1 slapping Resident #2 across the forehead. However, this allegation of resident-to-resident abuse was not reported to AAA.

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

This incident was reported to AAA on 5/29/26 by Administrator.

When incident occurred Administrator immediately gathered information from all staff who witnessed the event. Per witnessing staff Resident #1 had not slapped Resident # 2. Resident #1 placed two fingers on Resident # 2's forehead. Resident # 2 was immediately assessed for any injury and no injuries were noted. Residents were separated from each other and no further incidents occurred.

Documentation of incident will be reviewed with staff member responsible for the documentation by 6/5/26 by Memory Care Coordinator.

Director of Wellness will review proper documentation practices at nursing meeting by 6/26/26.

Director of Wellness will review all incident reports and nursing documentation daily Monday-Friday x 2 weeks beginning 6/1/26, then weekly x 2 weeks, then monthly x 2 months to ensure continued compliance with regulation.

Licensee's Proposed Overall Completion Date: *06/29/2026*

Implemented ([redacted] - 06/30/2026)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 1/30/26, Staff Member A observed Resident #1 slapping Resident #2 across the forehead. However, this allegation of abuse was not reported to the Department.

On [redacted] Resident #3 grabbed Staff Member B by the shirt and dragged [redacted] down the hall, causing Staff member B to choke. The police were called and responded to the home. Resident #3 was taken to the hospital, for medical evaluation. This incident required the services of law enforcement and EMS, however it was not reported to the Department.

16c - Written Incident Report (continued)

Repeated Violation -10/9/25, et al.

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

These incidents were reported to Department on 5/29/26 by Administrator.

When incident on 1/30/26 occurred Administrator immediately gathered information from all staff who witnessed the event. Per witnessing staff Resident #1 had not slapped Resident # 2. Resident #1 placed two fingers on Resident # 2's forehead. Resident # 2 was immediately assessed for any injury and no injuries were noted. Residents were separated from each other and no further incidents occurred.

Documentation of incident will be reviewed with staff member responsible for the documentation by 6/5/26 by Memory Care Coordinator.

Director of Wellness will review proper documentation practices at nursing meeting by 6/26/26.

Administrator will review reportable incidents and timely reporting at all staff meeting by 6/26/26.

Director of Wellness will review all incident reports and nursing documentation daily Monday-Friday x 2 weeks beginning 6/1/26, then weekly x 2 weeks, and then monthly x 2 months to ensure all incidents are reported properly and to maintain continued compliance with regulation.

Licensee's Proposed Overall Completion Date: *06/29/2026*

Implemented ([redacted] - 06/30/2026)

103c - Food Protected

3. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 5/5/26 at 2:18 PM, a used and unsealed 32 oz. bag of Pioneer golden light brown sugar was stored in a cupboard located in the SDCU kitchenette.

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

Bag of brown sugar was immediately disposed of by Administrator during inspection on 5/5/26.

Education to be provided to all staff by Administrator during all staff meetings by 6/26/26 regarding safe storage

103c - Food Protected (continued)

of food.

An audit is to be completed of all food storage areas by Executive Chef by 5/22/26 to ensure all food is stored properly.

Executive Chef to audit all food storage areas weekly x 4 weeks beginning 5/26/26 and then monthly x 2 months to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *06/24/2026*

Implemented ([redacted] - 06/30/2026)

132g - Fire Drills Days/Times

4. 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 home routinely holds sleeping fire drills between 5:53 AM and 6:05 AM as evidenced by the following fire drills: 4/18/24 at 6:04 AM, 10/8/24 at 6:04 AM, 4/17/25 at 6:05 AM, and 10/22/25 at 5:53 AM

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

Administrator and Maintenance Director reviewed regulation on 5/20/26.

Maintenance Director to begin completing sleeping fire drills between the hours of 10:00PM and 6:00AM with emphasis on alternating times. This will begin with a fire drill in the month of July 2026.

Administrator will audit fire drill logs monthly beginning May 2026 to ensure continued compliance with regulation.

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

Implemented ([redacted] - 06/30/2026)

141a 1-10 Medical Evaluation Information

5. 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.

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

Description of Violation

Resident #3's medical evaluation, dated [redacted], indicated the resident's needs can be met safely at the Personal Care Home. The same medical evaluation also indicated that the Resident is Nursing Facility Clinically Eligible. Services to be provided at home or in a nursing facility. The resident's needs CAN NOT be met safely at the Personal Care Home.

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

Education was provided to Director of Wellness by Administrator on 5/20/26 regarding requirements of 141a.

Director of Wellness had a new medical evaluation form completed to correct the violation on 5/20/26.

Director of Wellness to complete an audit of all resident charts to ensure the medical evaluations indicate that all residents needs can be met at the Personal Care Home by 5/22/26.

Administrator to audit 10 resident records weekly x 4 weeks beginning 5/26/26, and then monthly x 2 months to ensure continued compliance with regulation.

Licensee's Proposed Overall Completion Date: *06/19/2026*

Implemented ([redacted] - 06/30/2026)

144c1 - Smoking Area Guidelines

6. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 5/5/26 at 9:15 AM, the home's designated smoking area contained 2 chair cushions that were not fire-resistant.

On 5/5/26 at 9:15 AM, 8 cigarette butts observed in the grass by the designated smoking area.

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

On 5/5/26 Administrator removed the 2 chair cushions and disposed of them immediately. On 5/5/26 housekeeper cleaned up all cigarette butts observed in the grass by the smoking area.

On 5/20/26 enclosed ashtrays were placed at smoke hut by maintenance director to prevent cigarette butts from blowing out of ashtray.

Housekeeping director to audit the smoking area once daily Monday through Friday for 2 weeks beginning 5/18/26, then weekly x 2 weeks, and then monthly x 2 months to ensure there are no cushions, flammable materials, or cigarette butts outside of the smoking area.

Education to be provided to all staff by Administrator during all staff meeting by 6/26/26 to review "Proper

144c1 - Smoking Area Guidelines (continued)

safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms."

Licensee's Proposed Overall Completion Date: *06/26/2026*

Implemented ([redacted] - 06/30/2026)

162c - Menus Posted

7. 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

On 5/5/26, the menu for the current week was posted. However, the menu for one week in advance was not posted in the Personal Care section of the home.

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

On 5/5/26 the menus were immediately updated by Executive Chef.

Education provided to Executive Chef by Administrator on 5/6/26 regarding requirements for posting menus.

Audit to be completed by Administrator weekly x 4 weeks beginning 5/26/26, then monthly x 2 months to ensure the proper menus are posted.

Licensee's Proposed Overall Completion Date: *06/24/2026*

Implemented ([redacted] - 06/30/2026)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/5/26, Systane lubricant eye drops prescribed to Resident #4 were present in the medication cart and labeled with a date opened of 10/13/25. However, according to the manufacturer's instructions this medication is to be discarded 90 days after opening.

Repeated Violation- 10/17/24, et al.

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

The medication was immediately removed and reordered by LPN on duty on 5/5/26.

Education provided to all med techs and LPNs regarding ensuring that medications are not expired at nursing meeting by Director of Wellness on 5/28/26.

183e - Storing Medications (continued)

Director of Wellness to audit all med carts by 5/29/26 to ensure there are no expired medications present.

Director of Wellness to audit carts weekly x 4 weeks beginning 6/5/26 to ensure continued compliance to regulation.

Med tech or LPN on duty on night shift to audit cart for expired medications based on room number beginning 6/1/26 and ongoing. For example rooms A1, B1, and D1 will be audited on the first of each month.

Licensee's Proposed Overall Completion Date: *06/26/2026*

Implemented ([redacted] - 06/30/2026)

184a - Resident's Meds Labeled

9. 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

On 4/22/26, Resident #2 received an order for Carbidopa-Levodopa 15-100mg, three times daily. However, on 5/5/26, Resident #1's pharmacy label had instructions to take 1 tablet by mouth two times daily.

On 5/1/26, Resident #5 received an order for Novolog Flex Pen U-100 Insulin Aspart 100unit/mL, inject 4 units Q before meals, inject before meals per sliding scale: 0-199=0, 200-250=2, 251-300=3, 301-350=4, 351-400=5. However, on 5/5/26, Resident #5's pharmacy label indicated a sliding scale of: 0-100=1, 101-199=6, 200-250=8, 251-300=9, 301-350=10, 351-400=11

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

Direction changed stickers were immediately applied to medications by LPN on duty on 5/5/26.

Education provided to all med techs and LPNs regarding requirements of regulation 184a by Director of Wellness at nursing meeting on 5/28/26.

Director of Wellness to audit all med carts by 5/29/26 to ensure all medication labels match the prescribed instructions.

Director of Wellness to audit carts weekly x 4 weeks beginning 6/5/26 to ensure continued compliance to regulation.

Med tech or LPN on duty on night shift to audit cart using the MAR and matching labels on medications to the prescribed orders based on room number beginning 6/1/26 and ongoing. For example rooms A1, B1, and D1 will be audited on the first of each month.

Licensee's Proposed Overall Completion Date: *06/26/2026*

Implemented ([redacted] - 06/30/2026)

185a - Implement Storage Procedures

10. 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 #2 is prescribed Lorazepam, Mucinex, and Nystatin to be administered as needed. On 5/5/26 at 5:45 PM, these medications were not available in the home.

The home's policy for Controlled Substance Administration & Accountability states, "All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record." On 5/5/26 at 5:48 PM there were 34 Oxycodone HCL tablets, prescribed to Resident #4, present in the blister packs. However, the count sheet indicated there were 35 Oxycodone HCL tablets remaining.

Repeated Violation- 10/17/24, et al.

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

Lorazepam was reordered by Memory Care Coordinator on 5/5/26 to be made available to resident. Received from pharmacy on 5/6/26.

Nystatin and Mucinex were discontinued by MD on 5/6/26 due to non-use.

All med techs and LPNS to be educated by Director of Wellness at nursing meeting by 6/26/26.

Director of Wellness to complete audit of all med carts to ensure all medications ordered are available by 6/2/26.

Director of Wellness to audit carts weekly x 4 weeks beginning 6/5/26 to ensure continued compliance to regulation.

Med tech or LPN on duty on night shift to audit cart for availability of medications based on room number beginning 6/1/26 and ongoing. For example rooms A1, B1, and D1 will be audited on the first of each month.

Employee responsible for missing signature was educated on 5/29/26 by Director of Wellness and Memory Care Coordinator.

On 5/5/26 Administrator reviewed MAR and narcotic log sheet determining that a signature had been missed in the narcotic log at 1200 on 5/5/26. Employee responsible for missing signature corrected the error on 5/7/26.

All med techs and LPNs were educated on narcotic documentation on 5/28/26 at nursing meeting by Director of Wellness.

Director of Wellness to audit narcotic record daily Monday-Friday for 2 weeks beginning 6/1/26, then weekly x 2 weeks, and then monthly x 2 months to ensure continued compliance.

185a Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *06/26/2026*

Implemented ([redacted] - 06/30/2026)

187c - Refusal of Medication

11. 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 #6 is prescribed Novolog Flexpen Syringe, inject 6 units subq before meals. On 5/1/26 5/4/26 at 7:30 AM and 5/4/26 at 4:30 PM, Resident #6 refused the administration of Novolog; the home did not notify the prescriber of these refusals.

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

MD was notified on 5/6/26 by LPN that the medication was refused 5/1/26 5/4/26 at 7:30AM and 5/4/26 at 4:30PM.

Med Techs and LPNs to be educated by Director of Wellness during nursing meeting on 5/28/26 regarding notification of MD when a resident refuses a medication.

Director of Wellness to audit 10 resident MARs weekly x 4 weeks beginning 5/26/26, and then monthly x 2 months to ensure continued compliance with regulation.

Licensee's Proposed Overall Completion Date: *06/24/2026*

Implemented ([redacted] - 06/30/2026)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #5 is prescribed Midodrine HCL 2.5 MG, take 1 tablet by mouth 3 times daily before meals hold for SBP greater than 140. On 5/3/26 at 4:30 PM, the resident's systolic blood pressure was 141, however this medication was administered.

Repeated Violation 10/17/24, et al.

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

MD was notified on 5/20/26 by LPN that the medication was not held as ordered on 5/3/26.

Med Techs and LPNs to be educated by Director of Wellness during nursing meeting on 5/28/26 regarding following prescriber's orders.

187d - Follow Prescriber's Orders (continued)

Director of Wellness to audit 10 resident MARs weekly x 4 weeks beginning 5/26/26, and then monthly x 2 months to ensure continued compliance with regulation.

Licensee's Proposed Overall Completion Date: *06/24/2026*

Implemented ([redacted] - 06/30/2026)

190c - Record of Training

13. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff Member C completed the Department-approved medication administration course on 3/6/25. However, the home's medication administration training record for did not include Staff Member C's initial user report.

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

Administrator requested initial user report from Staff Member C on 5/29/26. Med Tech will not work on floor as med tech until document is received.

Administrator reviewed requirements of 190c on 5/29/26.

Administrator to audit all med tech documentation by 6/5/26 to ensure compliance with regulation.

Administrator to audit med tech documents monthly x 3 months to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Implemented ([redacted] - 06/30/2026)

251c - Standardized Forms

14. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #4s medical evaluation, dated [redacted] was completed on the Department's current standardized form for Assisted Living Residence; Resident #4 resides in a Personal Care Home.

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

Education was provided to Director of Wellness by Administrator on 5/20/26 regarding using standardized forms to record resident information.

Director of Wellness had a new medical evaluation form completed to correct the violation on 5/20/26.

251c - Standardized Forms (continued)

Director of Wellness to complete an audit of all resident charts to ensure the proper standardized forms are being used to record medical evaluations by 5/22/26.

Administrator to audit 10 resident records weekly x 4 weeks beginning 5/26/26, and then monthly x 2 months to ensure continued compliance with regulation.

Licensee's Proposed Overall Completion Date: *06/23/2026*

Implemented ([redacted] - 06/30/2026)