pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SUNNY CREST HOME INC**
LEGAL ENTITY

To operate **SUNNY CREST HOME**
NAME OF FACILITY OR AGENCY

Located at **2587 VALLEY VIEW ROAD, MORGANTOWN, PA 19543**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **71**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 25, 2026** until **February 25, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **321921**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 25, 2026

Sunny Crest Home, Inc.
[redacted]

RE: Sunny Crest Home
2587 Valley View Road
License/COC #: 321921

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on May 20, 2026, May 21, 2026, July 22, 2026 and July 23, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance License #33309 dated November 20, 2025 until November 20, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from AUGUST 25, 2026 to FEBRUARY 25, 2027.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
60(a)	II	50	$5	$250	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: [redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SUNNY CREST HOME* **License #**: *32192* **License Expiration**: *11/20/2026*

Address: *2587 VALLEY VIEW ROAD, MORGANTOWN, PA 19543*

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

Administrator

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

Legal Entity

Name: *SUNNY CREST HOME INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *08/05/2007* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *58* **Waking Staff**: *44*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/22/2026*

Inspection Dates and Department Representative

05/20/2026 On Site: [redacted]

05/21/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *71* **Residents Served**: *51*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *25* **Are 60 Years of Age or Older**: *29*

Diagnosed with Mental Illness: *16* **Diagnosed with Intellectual Disability**: *22*

Have Mobility Need: *7* **Have Physical Disability**: *2*

Inspections / Reviews

05/20/2026 Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/25/2026*

06/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/03/2026*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/03/2026*

07/06/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/03/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/20/2026*

08/10/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/03/2026*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted], the home's licensing inspection summary dated [redacted] was not posted in a conspicuous and public place in the home.

Repeated Violation – [redacted] et al

Plan of Correction ***Accept ([redacted] - 06/26/2026)***

See attached.
5/21/2026 the licensing inspecting summary dated 8/18/2025 was posted immediately after discovering it was missing.
Administrator will review and post all required documents in a conspicuous place in the home- starting 5/21/2026- a monthly checklist was made to ensure it doesn't happen again.

Licensee's Proposed Overall Completion Date: *06/22/2026*

Implemented ([redacted] 08/10/2026)

5a1 - DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted] at 3:30 PM, an agent of the Department requested access to [redacted] and additional training required by the home's waiver for Staff Member A. The records were not provided by the end of the inspection.

Plan of Correction ***Accept [redacted] - 07/06/2026)***

6/29/2026The administrator/Admin service manager and Medical secetery were re-education on the requirement to maintain immedate access to all records,organized and inspection ready at all times. Training done by the Facility Director . Starting 7/15/2026 a monthly audit will be done to verify all records are complet and current. And administtrator will retain a copy of the records and have them readily avaliable for immedatly access

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 08/10/2026)

15a - Resident Abuse Report

3. Requirements

2600.

15a Resident Abuse Report *(continued)*

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 [redacted] at 9:47 AM, staff interviews reported to agents of the Department that several months earlier, Resident [redacted] reported that Resident [redacted] had punched [redacted] and thrown [redacted] down the stairs. Resident [redacted] confirmed that Resident #[redacted] had hit Resident [redacted]. The home did not report the incidents to the Area Agency on Aging.

On [redacted] at approximately 11:00 AM, multiple staff interviews indicated that between February 2026 and March 2026, Area Agency on Aging responded to a report of abuse at the home between Residents [redacted] and [redacted]. Staff interviews reported that there was yelling between residents that "got to a toxic level." Staff interviews indicated during the incident, Resident [redacted] had told Resident [redacted] to shut up and was screaming at [redacted] causing Resident [redacted] to react by yelling back and trying to get away from Resident [redacted]. The home did not report this incident to the Area Agency on Aging.

Plan of Correction ***Directed [redacted] - 07/06/2026)***

The Administrator will review incident and reports within 24 hours. Staff will be re train on incident reporting at the staff meeting 7/15/2026, weekly audit of incident reports, and a follow up with monthly audits will start 7/1/2026 to check for any deficiencies.

(Directed)
In addition to the above plan of correction:

- *The administrator or designee will complete and submit an Act 13 to the local Area Agency on Aging for all incidents identified in the violation by 7/20/26.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

16c - Written Incident Report

4. 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 [redacted] at 9:47 AM, staff interviews reported to agents of the Department that several months earlier, Resident [redacted] reported that Resident [redacted] had punched [redacted] and thrown [redacted] down the stairs. Resident [redacted] confirmed that Resident [redacted] had hit Resident [redacted] The home did not report this to the Department.

On [redacted] at approximately 11:00 AM, multiple staff interviews indicated that between February 2026 and March

16c Written Incident Report (continued)

2026, Area Agency on Aging responded to a report of abuse at the home between Residents [redacted] and [redacted]. Staff interviews reported that there was yelling between residents that "got to a toxic level." Staff interviews indicated during the incident, Resident [redacted] had told Resident [redacted] to shut up and was screaming at [redacted] causing Resident [redacted] to react by yelling back and trying to get away from Resident [redacted] The home did not report this to the Department.

Plan of Correction ***Directed [redacted] - 07/06/2026)***

7/15/2026
Staff will be re trained on incident reporting requirements at the monthly staff meeting
6/30/2026 Administrator will review all incident reports daily and re train all staff on required reporting for compliance.
Proposed Overall Completion Date: 06/30/2026

(Directed)
In addition to the above plan of correction:

- *The administrator or designee will complete and submit a Reportable to the Department for all incidents identified in the violation by 7/20/26.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

19 - Review Waiver

5. Requirements

2600.
19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

On [redacted], the home received a waiver of 55 Pa Code § 2600.190(b) relating to medication administration training to allow unlicensed direct care staff to administer subcutaneous injections of [redacted] medications. A copy of the Department's written decision was not posted in a conspicuous and public place within the home.

Repeated Violation [redacted] et al

Plan of Correction ***Accept [redacted] - 07/06/2026)***

See attached
The wavier was posted 6/24/2026 by the administrator. The administrator will implement mandatory training for all staff on requirements of the 55 pa. 2600 at the staff meeting on 7/15/2026. A checklist was implemented to ensure we stay in complance.

19 Review Waiver (continued)

Proposed Overall Completion Date: 06/30/2026

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented [redacted] - 08/10/2026)

51 - Criminal Background Check

6. 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 Member F was hired on [redacted]. The home did not obtain a Pennsylvania State Police Criminal Background Check until 2/24/2026.

Staff Member G, hired on [redacted], did not have a report of federal criminal history record information from the Federal Bureau of Investigation. Staff Member G resided in outside of Pennsylvania within the previous two years prior to the staff's date of hire.

Staff Member H was hired on [redacted]. The home did not obtain a Pennsylvania State Police Criminal Background Check until [redacted]

Plan of Correction ***Directed [redacted] 07/06/2026)***

See attached.
5/21/2026 The employee FBI criminal background check was obtained and placed in the employee file. Starting 6/30/2026 All audits will be done by the Admin service manager at the time of hire for all employees

(Directed)
In addition to the above plan of correction:

- *Education will be provided to all staff responsible for obtaining background checks for newly hired staff by 7/20/26.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Not Implemented [redacted] - 08/10/2026)

57b - 1 Hour/Day

7. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

57b - 1 Hour/Day *(continued)*

Description of Violation

On [redacted] there were 52 residents in the home, requiring a minimum of 52 hours of direct care service. On this day, only 37.5 hours of direct care staffing was provided.

On [redacted] there were 52 residents in the home, requiring a minimum of 52 hours of direct care service. On this day, only 37.5 hours of direct care staffing was provided.

Plan of Correction ***Accept ([redacted] 07/06/2026)***

Administrator will educate the Direct Care supervisor and admin. services manager on properly staffing per 2600.complance by 7/1/2026. Administrative service manager will do an audit prior to implementation of the schedule starting 7/1/2026. Administrator will educate all staff starting 7/13/2026 on proper staffing caluclation and over view processes to asure regulatory complance.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented [redacted] 08/10/2026)

60a - Staff/Support Plan

8. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted] and [redacted] from 10:00PM – 6:00AM, there was one staff scheduled on shift in the home. Two residents who resided in the home at this time required two-person assistance to utilize their Hoyer lifts and/or evacuate in the case of an emergency.

Repeated Violation – [redacted], et al, [redacted], et al

Plan of Correction ***Directed [redacted] - 07/06/2026)***

Administrator will educate the Direct Care supervisor and admin. services manager on properly staffing per 2600.complance by 7/1/2026. Administrative service manager will do an audit prior to implementation of the schedule starting 7/1/2026. Administrator will educate all staff starting 7/13/2026 on proper staffing caluclation and over view processes to asure regulatory complance.

(Directed)
In addition to the above plan of correction:

- *Beginning immediately, at least two staff members will be scheduled per shift.*
- *The administrator or designee will audit all resident lifting/transferring/ambulation needs to determine which residents require more than one person to assist by 7/20/26. A list will be created identifying the residents with the need for at least two staff persons or more to assist when lifting/transferring or ambulating. This list will be used to determine if more than two staff members are required to be scheduled per shift.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

60a - Staff/Support Plan *(continued)*

Directed Completion Date: *07/20/2026*

Not Implemented (08/10/2026)

62 - Contact List

9. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person D, the administrator, did not maintain a current list of names, addresses, and telephone numbers of staff persons including substitute personnel.

Plan of Correction ***Directed - 07/06/2026)***

On 6/29/2026 Administrator will educate Administrative service manager on requirement to maintain a current and accurate record all staff list. 2600.62 The training will include updating the staff roster whenever there is a new hire. Starting 7/13/2026 Administrator will verify employee information during orentation and require staff to report any changes and contact information.

(Directed)
In addition to the above plan of correction:

- *Beginning no later than 7/20/26, the administrator or designee will complete monthly audits for a minimum of three months to ensure the list of staff persons, substitute personnel and volunteers remains current with names, addresses and telephone numbers.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented - 08/10/2026)

63a - First Aid/CPR Training

10. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On from 10:00 PM – 6:00 AM, 51 residents were present in the home. During this time, only 1 staff person was present in the home who was certified in First Aid/CPR.

Repeated Violation – et al

Plan of Correction ***Directed (- 07/06/2026)***

See Attached:
All of our staff had successfully completed the CPR training including agency staff.
The LPN staff monitor the CPR for all staff. 7/1/2026 classess are schedule for CPR 9/11@ 9:00 am

63a First Aid/CPR Training (continued)

(Directed)

- *Education will be provided to the administrator and or any additional staff responsible for scheduling on regulation 2600.63(a) by 7/10/26.*
- *Beginning no later than 7/10/26, the administrator or designee will complete a staff schedule at least one week in advance and ensure there is at least one staff member scheduled certified in CPR and FA for every 50 residents in the home.*
- *Documentation of completed education and schedules will be kept in the home and available for review by the Department.*

Directed Completion Date: *07/10/2026*

Implemented ([redacted] 08/10/2026)

65a - FS Orientation 1st Day

11. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Member F, whose first day of work was [redacted] did not receive orientation on any of the training topics as specified in 2600.65(a).

Staff Member H, whose first day of work was [redacted] did not receive orientation on any of the training topics as specified in 2600.65(a).

Plan of Correction ***Directed [redacted] 07/06/2026)***

Staff agency F and H have not worked in the facility since 2/2026 They will not work in the facility untill they have recieved orientation and fire safety training with the designate staff

(Directed)

- *Education will be provided to staff member(s) responsible for providing training in accordance with 2600.65(a) by 7/20/26.*
- *An initial audit on all other staff records (including agency staff) will be completed by 7/15/26 to ensure compliance with 2600.65(a). Any staff members found to be missing the required training will have the training completed by 7/20/26.*
- *Beginning no later than 7/20/26, the administrator or designee will review all newly hired staff training records by the completion of the staff member's first day.*

65a FS Orientation 1st Day (continued)

- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

65b - Rights/Abuse 40 Hours

12. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member F, hired on [redacted] has since completed [redacted] 40th scheduled work hour. However, this staff member did not complete training in any of the training topics as identified in 2600.65(b).

Plan of Correction ***Directed [redacted] - 07/06/2026)***

5/21/2026 The agency staff F will have orentation training prior to filling any shifts. However [redacted] has not been back to the facility since 2/2026 . Administrative service manager will document this training and have available upon request . Administrator will review all staff member file to verify orientation was given Effective immediately starting 7/13/2026

(Directed)

- *Education will be provided to staff member(s) responsible for providing training in accordance with 2600.65(b) by 7/20/26.*
- *An initial audit on all other staff records (including agency staff) will be completed by 7/15/26 to ensure compliance with 2600.65(b). Any staff members found to be missing the required training will have the training completed by 7/20/26.*
- *Beginning no later than 7/20/26, the administrator or designee will review all newly hired staff training records by the completion of the staff member's 40th scheduled working hour.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

65e - 12 Hours Annual Training

13. Requirements

2600.

65e - 12 Hours Annual Training *(continued)*

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff Member L received only 6 hours of annual training in training year 2025.

Plan of Correction ***Directed ([redacted] - 07/06/2026)***

in O 6/29/2026- Administrator reviewed all employee training record for 2025 and dentified staff with incomplete training . Starting 7/13/2026 Administrator will do a monthly audit of all employee training records for 2025 & 2026 and document them. Staff that were identified were given a warning and a time to complete by 7/15/2026

(Directed)
In addition to the above plan of correction:

- *Education on regulation 2600.65(e) be provided to the staff member(s) responsible for providing training to all staff by 7/20/26.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

65f - Training Topics

14. 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 training in the following topics during training year 2025:

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*

Staff Member L did not receive training in the following topics during training year 2025:

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

65f - Training Topics (continued)

Plan of Correction ***Directed [redacted] - 07/06/2026)***

6/29/2026- Administrator reviewed all employee training record for 2025 and dentified staff with incomplete training . Starting 7/13/2026 Administrator will do a monthly audit of all employee training records for 2025 & 2026 and document them. Staff that were identified were given a warning and a time to complete by 7/15/2026

(Directed)
In addition to the above plan of correction:

- *Education on regulation 2600.65(f) be provided to the staff member(s) responsible for providing training to all staff by 7/20/26.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

65g - Annual Training Content

15. 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.
3. Resident rights.
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 training in the following topics during training year 2025:

- *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.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*

Staff Member L did not receive training in the following topics during training year 2025:

- *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.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*
- *Falls and accident prevention.*

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept [redacted] - 07/06/2026)***

6/29/2026- Administrator reviewed all employee training record for 2025 and dentified staff with incomplete training . Starting 7/13/2026 Administrator will do a monthly audit of all employee training records for 2025 & 2026 and document them. Staff that were identified were given a warning and a time to complete by 7/15/2026 . The administrator will train all staff 7/6/2026 on regulation 2600.65(g)

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented [redacted] - 08/10/2026)

82c - Locking Poisonous Materials

16. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] at 9:40 AM, eye wash with a manufacturer's label indicating to contact the poison control center was unlocked, accessible and unattended in the employee lounge.

On [redacted] at 3:35 PM, Remedy antifungal powder, with a manufacturer's label indicating to contact the poison control center was unlocked, accessible and unattended in resident room [redacted]

Not all residents in the home are assessed to safely use or avoid poisonous materials, including Resident [redacted]

Repeated Violation – [redacted] et al

Plan of Correction ***Directed [redacted] 07/06/2026)***

Poisnous materials shall be kept locked and inaccessible to residents.
5/20/2026 -The eye wash station were removed immediately .
5/20/2026-Maintenance staff re-trained on poisnous materials and accessablity to residents, As of 5/22/2026 - Maintenance Staff supervisor will montor daily to keep it from happening

(Directed)
In addition to the above plan of correction:

- *The administrator or designee will complete an initial audit by 7/15/26 of the entire home to ensure all poisonous materials including over the counter medications are kept locked and inaccessible to residents.*
- *All staff who work in the home will receive education on 2600.82(c) by 7/20/26.*
- *Beginning no later than 7/20/26, the administrator or designee will complete weekly audits of the entire home to ensure poisonous materials remain locked and inaccessible to residents.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

82c - Locking Poisonous Materials (continued)

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

85a - Sanitary Conditions

17. Requirements

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

Description of Violation

On [redacted] at approximately 9:41 AM, feces and excessive toilet paper were observed in the left toilet of the men's common bathroom leading from the activity area. A 2" spot of loose feces was observed on the floor next to the toilet and the bathroom had a strong odor.

Plan of Correction ***Accept [redacted] 07/06/2026)***

5/20/2026- Housekeeping and direct care staff were notified of the sanitation concern, the tiolet was immediately cleaned and restore to proper working condition. The feces on the bathroom floor were promptly removed and the affected area was thoroghly cleaned 5/20/2026 - Housekeeping staff were instructed on maintaining clean and sanitary condition throughout the home. Housekeeping staff clean the furniture immedately.. on 5/21/2026 Housekeeping staff supervisor will document completion of daily cleaning tasks and monitor the cleaning process, to keep this from happening. Starting 6/30/2026 Administration will follow up with daily walk through.

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

Implemented [redacted] - 08/10/2026)

95 - Furniture and Equipment

18. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On [redacted] at 11:25 AM, the loveseat and multiple upholstered chairs were heavily stained and soiled; particles of food and other debris were also observed on the furniture.

Plan of Correction ***Accept [redacted] - 06/26/2026)***

5/21/2026- Housekeeping was notified of the dirty furniture in the activity area.
5/21/2026- Housekeeping staff were instructed to throughly clean and disinfect furniture
AS of 5/22/2026- Housekeeping staff will include furniture cleaning as a part of the routine daily cleaning schedule. Administration will follow up daily to ensure sanitation.

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

Implemented ([redacted] - 08/10/2026)

102i - Soap Dispenser

19. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On [redacted] at 9:33 AM and again at 3:11 PM, an unlabeled used bar of soap was present in the A-wing shared shower room.

On [redacted] at 3:00 PM, an unlabeled used bar of soap was present in the bathtub in the B-wing shared shower room.

Plan of Correction ***Accept ([redacted] - 06/26/2026)***

5/21/2026-The bar soap was removed immediately upon discovery. Resident hygiene items will be reviewed to ensure proper storage and identification. 5/21/2026 Housekeeping supervisor was re- educated and will monitor the restroom to ensure this does not happen. Administration will follow up daily to ensure compliance.

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

Implemented [redacted] - 08/10/2026)

103e - Left Overs

20. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On [redacted] at 4:04 PM, the following leftover food items were in the home's walk-in freezer:

- *Multiple unlabeled, undated plates of food that included what appeared to be a hashbrown and fish*
- *An unlabeled, undated plate of vegetables*
- *A hard-boiled egg and cheese*
- *Unlabeled, undated trays of various food items including pieces of pies, fruit cups, cup of cottage cheese, and puddings*

Plan of Correction ***Accept [redacted] - 06/26/2026)***

5/21/2026 - unlabeled undated or improprly stored food items were discarded. 5/21/2026
Dietary staff have been re-educated on food safety ,including proper labeling .Starting 5/22/2026 dietary staff supervisor will check dates,and proper storage of all leftover food daily. Administrator will monitor daily.

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

Implemented [redacted] - 08/10/2026)

121a - Unobstructed Egress

21. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 10:20 AM, the door to resident bedroom[redacted] would not open without force as the door was not properly affixed to the hinges and door frame, blocking egress from the room.

Plan of Correction ***Accept[redacted] - 07/06/2026)***

5/20/2026- The obstruction was removed immediately upon identification the residents door was inspected and repaired. -5/20/2026 Maintenance staff was re-educated on all exits should be accessable at all times. Starting 5/21/2026 Maintenance Supervisor will follow up during daily inspections. Administrator will do a daily monitoring.5/25/2026 the Administrator and maintenance supervisor did and audit on all the room doors and found another door that needed adjustment and immediately adjusted it to keep in good working order this was done by maintenance staff 6/30/2026

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

Implemented ([redacted] - 08/10/2026)

123b - Emergency Procedures Posted

22. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept[redacted] - 07/06/2026)***

See attached.
5/23/2026 - Emergency procedure was posted immediately. The administrator will verify that emergency procedure were posted and accessible for review. A monthly checklist starting 7/1/2026 will be completed to verify compliance with regulations

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

Implemented[redacted] - 08/10/2026)

132h - Designated Meeting Place

23. 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 fire drills, the home begins timing the evacuation when the alarm is activated and stops the timer after staff have evacuated residents from the immediate location of the simulated fire. The documented evacuation time does

132h Designated Meeting Place (continued)

not include the evacuation time for residents in other wings or common areas of the home.

Plan of Correction ***Accept (07/06/2026)***

5/22/2026 The Administrator reviewed the policies and procedures and updated as needed. Maintance supervisor was trained on evacuation policies per 2600.132(h) a fire drill was done 6/30/2026 at 1:58pm. All resident were in a safe area in 6 min. and 1sec. All staff were trained on fire procedure. It was determined that the overall time of evacuation was documented and was within the alotted time given per fire safety expert. The documented time was not recorded on the proper document but instead recorded on the fire drill
Maintenance staff supervisor was trained on propper documatation of evacuation records. 6/30/2026
Administrator will conduct a monthly audit to ensure propper documentaion is recorded starting 7/15/2026

Licensee's Proposed Overall Completion Date: *07/15/2026*

Not Implemented (- 08/10/2026)

183b - Meds and Syringes Locked

24. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On at 3:28 PM, Bengay Ultra Strength cream, antifungal powder, VicksVapo Rub, and Nystatin powder were unlocked, unattended, and accessible in resident bedroom

Repeated Violation , et al., , et al.

Plan of Correction ***Accept - 07/06/2026)***

5/20/2026 Upon immedate discovery the OTC medication was removed and discarded. All OTC medication items were placed in a locked box. Direct care staff will monitor daily starting6/29/2026 to ensure OTC items are locked and secure. RN staff will provide education to all staff on regulation 2600.183(b) at the staff meeting 7/1/2026

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

Implemented (- 08/10/2026)

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident was prescribed twice a day for . The pharmacy label for the medication indicated take every 1 hour as needed for

Plan of Correction ***Accept (- 07/06/2026)***

5/21/2026 The pharmacy was contacted and medication was properly labeled with correct information. Med Aide

184a - Resident's Meds Labeled (continued)

staff will review medication to ensure the labeles are correct. Med Aide staff will receive additional training on medication labeleing,by the Administrator and will conduct weekly audits starting 7/13/2026 to ensure compliance.

Proposed Overall Completion Date: 07/01/2026

Licensee's Proposed Overall Completion Date: 07/13/2026

Not Implemented [redacted] 08/10/2026)

-
-
-

190a - Completion Medication Course

29. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member A did not successfully complete the Department-approved medication administration course as evidenced by the lack of a Medication Administration Record review and pass observation for the annual practicum due in December 2025 or remediation. Staff Member A continued to administer medications to the following residents:
Resident [redacted] *on* [redacted] *at 7:00 AM and 1:00 PM*
Resident [redacted] *on* [redacted] *at 7:00 AM*
Resident [redacted] *on* [redacted] *at 7:00 AM*

Staff Member L did not successfully complete the Department-approved medication administration course. Staff Member L administered medications to the following residents:
Resident [redacted] *on* [redacted] *at 7:00 PM*
Resident [redacted] *on* [redacted] *at 8:30 PM*

Staff Member N did not successfully complete the Department-approved medication administration course. Staff Member N administered medications to the following resident:
Resident [redacted] *on* [redacted] *at 8:30 AM*

190a Completion Medication Course (continued)

Plan of Correction ***Directed [redacted] - 07/06/2026)***

See attached.
Med. Aide staff member has completed all the required training. The LPN staff member will do an audit every 3 months to ensure they stay in complance with the 2600. 190a starting 8/1/2026

(Directed)

- *Staff Member N completed the correct medication administration course; proper documentation will be filed in the staff members training record by 7/15/26.*
- *Staff Member A did not receive the required annual training for 2025 and will be removed from medication administration duties until the course is completed in its entirety.*
- *Staff Member L did not receive the required annual training for 2025 and will be removed from medication administration duties until the course is completed in its entirety.*
- *Education on medication administration training (initial and annual requirements) will be provided to staff member(s) responsible for obtaining staff medication administration training records by 7/15/26.*
- *An initial audit on all other staff records will be completed to ensure the correct medication administration training certification and timely annual practicum requirements have been completed by 7/20/26. Staff records found to be out of compliance will be removed from medication administration duties immediately until corrected. If staff member annual training records fall outside of the remediation timeline per ODP Guidelines, then they will be removed until the medication administration course is completed.*
- *Audits on staff medication administration training records will be completed quarterly starting 7/20/26 by the administrator or designee.*

Directed Completion Date: *07/20/2026*

Implemented [redacted] - 08/10/2026)

224a - Preadmission Screen Form

31. Requirements

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

Description of Violation

Resident [redacted] was admitted to the home on [redacted]; however, the resident's preadmission screening form did not indicate the date the screening was completed.

Repeated Violation [redacted], et al

Plan of Correction ***Accept [redacted] - 07/06/2026)***

See attached :
5/21/2026 Administrative service manager reviewed the pre screening document and added the missing date to complete the pre screening form. 5/22/2026 Asst. admin. was re trained on propper completion of

224a - Preadmission Screen Form (continued)

pre-screening forms. Administrator will do monthly audits to ensure compliance starting 7/13/2026

Licensee's Proposed Overall Completion Date: *07/13/2026*

Not Implemented - 08/10/2026)

225a - Assessment 15 Days

32. 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 was admitted to the home on . However, the resident's assessment was not completed until

Repeated Violation – et al

Plan of Correction ***Accept 07/06/2026)***

Residents records were reviewed to verify that all required assessment were current and completed within regulatory timeframes. As of 5/22/2026- a tracking system was implemented to monitor assessment due dates to provide advanced reminders for the Admin services manager. Administrator will conduct monthly audits to ensure compliance.
Administrative service manager was educated by the Administrator on 2600.225.a. on completing the assessment timely. Training will include -completion of the initial resident assessment in 15 days of admission- documentation on approve assessment from -the difference between initial resident assessment and resident support plan. This will be Implemented 7/13/2026 the Administrator will do a monthly audit on all residents and new intake of residents to ensure proper documentation.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented - 08/10/2026)

225c - Additional Assessment

33. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident sleeps on a mattress on the floor in the resident's bedroom. However, Resident assessment, dated , did not include the resident's need of an alternative sleeping arrangement of a mattress on the ground without a bedframe nor the assistance and/or services the resident may need in regard to the alternative sleeping arrangement.

225c Additional Assessment (continued)

Resident [redacted] assessment, dated [redacted], indicated that the resident was provided with prompting/cueing for transfers in/out of bed/chair. The assessment was not updated to include the resident's need for physical one staff assistance for transfers in/out of [redacted] wheelchair.

Resident [redacted] most recent assessment was completed [redacted]. The resident's previous assessment was completed on 5/24/2024.

Repeated Violation [redacted], et al

Plan of Correction ***Directed [redacted] - 07/06/2026)***

Administrative Aservice manager updated the assessment 5/22/2026 to include the missing items.An education done 5/29/2026 on regulation 2600.227(d) Changing the documentation for the support plan. Administrator will implement a service meeting 7/6/2026 with Direct Care supervisor,LPN staff RN staff and service manager to monitor any changes to the resident and upate support plan as needed

(Directed)

- *The administrator or designee will update the assessments for Residents [redacted], and [redacted] by 7/20/26.*
- *An initial audit will be completed on all resident assessments to ensure they accurately reflect resident needs by 7/20/26.*
- *Education will be provided to all staff members responsible for resident assessments on regulation 2600.225(c) to include updating resident assessments annually and as resident needs change by 7/20/26.*
- *Beginning 7/20/26, resident assessments will be audited at least once every 3 months to ensure assessments are updated annually and as a resident's condition changes.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Not Implemented [redacted] - 08/10/2026)

227d - Support Plan Medical/Dental

34. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for Resident [redacted], dated [redacted] indicated that the resident had the need for a bedside enabler to transfer out of bed to a wheelchair. The resident's support plan, dated [redacted] did not include the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used nor whether a cover is required to meet FDA guidelines.

227d - Support Plan Medical/Dental (continued)

Resident [redacted] utilizes a colostomy bag requiring colostomy care. However, Resident [redacted] support plan, dated [redacted], did not include the resident's use of a colostomy bag nor any staff supports to be provided.

Repeated Violation – [redacted], et al

Plan of Correction ***Directed [redacted] 07/06/2026)***

Administrative Aservice manager updated the assessment 5/22/2026 to include the missing items.An education done 5/29/2026 on regulation 2600.227(d) -Changing the documentation for the support plan. Administrator will implement a service meeting 7/6/2026 with Direct Care supervisor,LPN staff RN staff and service manager to monitor any changes to the resident and upate support plan as needed

(Directed)

- *The administrator or designee will update the support plans for Residents #6, and #14 by 7/20/26.*
- *The administrator or designee will complete an initial audit on all resident support plans to ensure they accurately reflect supports provided in the home by 7/2026.*
- *Beginning 7/20/26, resident support plans will be audited at least once every 3 months to ensure support plans accurately reflect supports provided in the home.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/20/2026*

Not Implemented [redacted] - 08/10/2026)