

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

September 21, 2026

[REDACTED], ADMINISTRATOR
FCNRC LP
911 DELAWARE STREET
FOREST CITY, PA, 18421

RE: FOREST CITY PERSONAL CARE
911 DELAWARE STREET
FOREST CITY, PA, 18421
LICENSE/COC#: 22349

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/27/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: FOREST CITY PERSONAL CARE

License #: 22349

License Expiration: 06/06/2027

Address: 911 DELAWARE STREET, FOREST CITY, PA 18421

County: SUSQUEHANNA

Region: NORTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: FCNRC LP

Address: 911 DELAWARE STREET, FOREST CITY, PA, 18421

Phone:

Email:

Certificate(s) of Occupancy

Type: C-2 LP

Date: 10/24/1994

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 26

Waking Staff: 20

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 05/27/2026

Inspection Dates and Department Representative

05/27/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 36

Residents Served: 23

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 23

Diagnosed with Mental Illness: 2

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 3

Have Physical Disability: 2

Inspections / Reviews

05/27/2026 Full

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 06/25/2026

07/13/2026 - POC Submission

Submitted By:

Date Submitted: 08/20/2026

Reviewer:

Follow-Up Type: POC Submission

Follow-Up Date: 07/17/2026

Inspections / Reviews (*continued*)

08/20/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/20/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/25/2026

09/21/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/20/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

At 9:15 a.m. the batteries for the Carbon Monoxide Monitor installed near the kitchen gas range were not labeled with the date they were installed. According to the Care Facility Carbon Monoxide Alarms Standards Act, batteries in carbon monoxide monitors must be changed annually.

Plan of Correction

Accept () - 07/13/2026

1. Maintenance immediately replaced the batteries in all Carbon Monoxide detectors and made sure the date was on the batteries.
2. Administrator will keep a log of when batteries were changed.

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

Implemented () - 09/21/2026

65g - Annual Training Content

2. 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.

Description of Violation

Staff persons A and B did not receive training in fire safety by a fire safety expert or a person trained by a fire safety expert during the training year 2025.

Plan of Correction

Accept () - 07/20/2026

1. Upon further investigation, 2025 annual training did have fire safety training, however, it was a video in a PowerPoint presentation. The video that was provided by a fire safety expert. This was provided by previous Administrator.
2. In-Person fire safety training for 2025 training year was done on 6/30/2026. Attached is Staff person A & B's 2025 annual fire safety training.
3. Fire Safety training for 2026 will be done December 2026.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026

65i - Training Record

3. Requirements

2600.

- 65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i Training Record (continued)**Description of Violation**

The home's record of direct care staff training for the 2025 training year did not include the length of each course trained.

Plan of Correction**Accept () - 07/13/2026)**

- 1. The home's record of direct care staff training for the 2025 training year was corrected to show the length of each course trained.*
- 2. Moving forward, the Administrator will be sure that each course has a length provided.*

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

Implemented () - 09/21/2026)**66a - Staff Training Plan****4. Requirements**

2600.

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

Description of Violation

The home did not have a complete staff training plan for the 2026 training year.

Plan of Correction**Accept () - 08/20/2026)**

- 1. An annual staff training plan is to improve direct care skills, ensure resident safety and meet state legal compliance.*
- 2. Administrator did not have the annual training planned out but immediately updated the annual staff training plan on 6/01/26 to indicate all training topics for the 2026 training year.*
- 3. Administrator has 2027 annual staff training attached.*

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026)**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

Resident #1's bed is equipped with a bedside mobility device. At 9:20 a.m. the mobility device was uncovered at the top. The opening was approximately 9 inches x 6 inches.

Plan of Correction**Accept () - 08/20/2026)**

- 1. Resident #1's bedside mobility device did not meet FDA guidelines. The opening was too big which could cause suffocation, strangulation or entrapment. The bedside device was immediately covered on 5/27/26 with a pillowcase until a proper covering was purchased.*
- 2. Administrator purchased a covering to go around mobility device to cover the opening. Covering was placed on device on 06/01/26. The opening is now 4x2 and meets FDA guidelines.*
- 3. DCS will check bedside device daily to ensure FDA guidelines are met.*

81b Resident Personal Equipment (continued)

4. Administrator will do weekly checks to be sure guidelines are met.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026

82c - Locking Poisonous Materials**6. 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

Bleach Cream Cleanser with a manufacture's label indicating "Harmful if ingested", was unlocked, unattended, and accessible to residents in the women's shower room. Not all residents of the home, including resident#2, have been assessed capable of recognizing and using poisons safely. Also, a bottle of Renown Mildew Cleaner with a manufacturer's label indicating "Harmful if swallowed" was unlocked, unattended, and accessible to residents in the men's shower room.

Plan of Correction

Accept () - 08/20/2026

1. Bleach Cream Cleanser & Renown Mildew Cleaner were immediately removed from the shower rooms on 5/27/26 and locked away in the cleaning cabinet.

2. Staff were in serviced on poisonous materials/cleaners. Poisonous materials/cleaners are not to be accessible to residents.

3. Administrator will do daily walk through to ensure no chemicals are accessible to residents.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026

85a - Sanitary Conditions**7. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At 9:35 a.m. a pile of towels and a pair of blue sweatpants were found on the shower chair in the men's common shower room.

Plan of Correction

Accept () - 07/13/2026

1. Towels and blue sweatpants were immediately removed from shower chair in the men's shower room by DCS.

2. Staff were re educated on removing all dirty linens from shower room when finished helping/bathing a resident.

3. Administrator will conduct daily walk through to ensure there are no dirty linens laying around/left behind.

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

Implemented () - 09/21/2026

96a - First Aid Kit**8. Requirements**

2600.

96a - First Aid Kit (continued)

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit stored in the medication room did not include eye coverings.

Plan of Correction

Accept () - 08/20/2026)

1. Administrator ordered eye coverings for first aid kit on 5/27/26. Eye coverings delivered on 5/30/26 and a pair was placed in first aid kit.
2. DCS will conduct monthly checks/audit to ensure all the correct items are in first aid kit.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026)

103f - Refrigerator/Freezer Temps**9. 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

At 11:45a.m., the refrigerator in the employee breakroom, which also contained resident food items such as frozen foods meals, did not have a thermometer in the refrigerator or freezer section.

Plan of Correction

Accept () - 07/13/2026)

1. Administrator immediately purchased thermometers for the refrigerator and freezer in the employee breakroom.
2. Administrator will do weekly checks/audits to be certain that all refrigerators and freezers have thermometers.

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

Implemented () - 09/21/2026)

103i - Outdated Food**10. Requirements**

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 1:15p.m., the kitchen dry storage closet contained a dented 6lb. can of Harvest Value Cheddar Flavor Sauce. Repeated violation 6/5/25.

Plan of Correction

Accept () - 07/20/2026)

1. Dietary staff immediately threw the dented can of Harvest Value Cheddar Flavor sauce away on 5/27/26.
2. Upon food delivery every Tuesday, dietary staff will inspect all dates on food along with checking for dented/damaged cans.
3. Dietary staff will also conduct weekly audits of canned items to ensure that there are no dented cans.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026)

105g Lint Removal and Duct Cleaning**11. 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

At 9:10 a.m. there was an approximate 1/4 inch accumulation of lint in the lint traps of the two dryers in the laundry room. There were no clothes in the dryers at the time.

Plan of Correction**Accept () - 07/13/2026)**

1. DCS immediately removed lint from the lint trap of both dryers.
2. DCS were re-educated on the importance of removing lint.
3. DCS will sign off daily, to ensure lint traps are being cleaned.

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

Implemented () - 09/21/2026)**121a Unobstructed Egress****12. 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

At 9:40 a.m. the exit door in the "private" hallway was jammed and could not be pushed open.

Plan of Correction**Accept () - 08/20/2026)**

1. Maintenance was notified and immediately fixed the issue on 5/27/26.
2. Maintenance/DCS will do daily checks to make sure all egress routes are not obstructed and functioning properly.

Licensee's Proposed Overall Completion Date: 07/24/2026

Implemented () - 09/21/2026)**132c Fire Drill Records****13. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted from 6/24/25 through 5/11/26 indicate exit routes used for each drill were "fire safe areas". According to staff interviews, residents are routinely evacuated to the outdoors using all available exits during fire drills. Also, the fire drill record for the drill conducted on 12/29/25 at 4:47 does not indicate if it was conducted in the a.m. or the p.m.

132c - Fire Drill Records (*continued*)**Plan of Correction**

Accept () - 08/20/2026

1. Fire drill records were corrected on 5/29/26 to indicate which exit route was used for each drill.
2. Administrator, moving forward, will be sure to specify which exit routes were used during fire drills. Also, AM or PM will be listed.
3. Fire drill on 12/29/25 was done at 4:47pm. This was corrected.

Licensee's Proposed Overall Completion Date: 08/14/2026

Implemented () - 09/21/2026

132f - Alternate Exit Routes

14. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The fire drill records for the drills conducted from 6/24/25 through 5/11/26 indicate exit routes used for each drill were "fire safe areas". According to staff interviews, residents are routinely evacuated to the outdoors using all available exits during fire drills. Staff stated that exits are not alternated for each fire drill and there is no simulated fire blocked exit.

Plan of Correction

Accept () - 08/20/2026

1. Fire drill records were corrected on 5/29/26 to indicate which exit routes were used.
2. Moving forward, Maintenance and Administrator will coordinate to conduct a simulated fire blocked exit for fire drills.

Licensee's Proposed Overall Completion Date: 07/24/2026

Implemented () - 09/21/2026

141a 1-10 Medical Evaluation Information

15. 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.

Description of Violation

Resident #3's annual medical evaluation did not include the date of the in person evaluation or the date the form was completed.

141a 1 10 Medical Evaluation Information (*continued*)**Plan of Correction**

Accept () - 07/13/2026)

1. Resident #3's annual medical evaluation was immediately corrected with the date of in person evaluation and date of when the form was completed.
2. Administrator will conduct monthly audits to be sure that in person evaluation and form completion dates are filled out on medical evaluation forms.

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

Implemented () - 09/21/2026)

181c - Self-administration Assessment

16. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #3 self administers their prescribed Cyanocobalam injection every three weeks; however, resident #3 has not been assessed by a physician, physician's assistant or certified registered nurse practitioner regarding ability to self administer this injection.

Plan of Correction

Accept () - 07/20/2026)

1. A physician's order for resident #3 to self administer Cyanocobalam injection was received on 8/05/2025.
2. Resident's DME from 10/16/25 notes that resident can self administer assistance in offering medication at prescribed times.
2. DCS will conduct monthly audits to be sure that the facility has a doctor's order for any resident capable of self administering medications.

Licensee's Proposed Overall Completion Date: 07/24/2026

Implemented () - 09/21/2026)

183e - Storing Medications

17. 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

The insulin Glargine pen belonging to resident #4 was not labeled with the date the pen was opened for use. According to the manufacturer's instructions, the insulin pen is to be discarded 28 days after it is opened for use.

Plan of Correction

Accept () - 07/13/2026)

1. Resident #4's Glargine insulin pen was immediately thrown away because it did not have a date on it to show when it was opened for use.
2. DCS were re educated on the importance of putting a date on insulin pens to show when the pen was opened for use.
3. DCS will keep track on "insulin tracking sheet" for each resident who is prescribed insulin.

183e - Storing Medications (*continued*)

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

Implemented () - 09/21/2026)

184a - Resident's Meds Labeled

18. 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 #5 is prescribed Oxycodone, one tablet every 8 hours as needed. The pharmacy label incorrectly indicates the medication order is one tablet every 4 hours as needed.

Plan of Correction

Accept () - 07/13/2026)

1. DCS received doctor order to D/C medication, Oxycodone, because resident was not taking it.
2. DCS were re-educated on the importance of checking doctor orders and checking pharmacy labels.

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

Implemented () - 09/21/2026)

225c - Additional Assessment

19. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1 uses a bedside mobility device. The resident's assessment dated () does indicate the resident utilizes a bedside mobility device. The Assessment does not indicate if there are any risks associated with the device, if the resident can use the device safely or if the FDA requires a covering of the device.

Resident #6 requires a strobe light to assist with evacuation due to hearing impairment when hearing aids are not being worn. However, the resident's assessment dated () did not include the need for the strobe light to evacuate.

Plan of Correction

Accept () - 07/13/2026)

1. DCS received a doctor's order for resident #1 to use a bedside mobility device.
2. Resident #1's RASP was updated on 6/2/2026 to indicate that () uses a bedside mobility device.
3. RASP specifies that resident #1 needs the device to help () get in and out of bed, daily. While the doctor's order states it is okay for resident to use device, any such device includes the risk of strangulation, suffocation and entrapment. The bedside mobility device now has a covering to comply with FDA guidelines.
4. Resident #6's RASP was updated on 6/2/2026 to indicate that the resident requires a strobe light to assist with evacuation due to hearing impairment when hearing aids are not being worn.

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

Implemented () - 09/21/2026)