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

July 21, 2026

[redacted] CEO
MELODY MANOR PCH LLC
413 NORTH MCKEAN STREET
KITTANNING, PA, 16201

RE: MELODY MANOR
413 NORTH MCKEAN STREET
KITTANNING, PA, 16201
LICENSE/COC#: 44676

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/28/2026 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: *MELODY MANOR* **License #**: *44676* **License Expiration**: *07/21/2026*

Address: *413 NORTH MCKEAN STREET, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MELODY MANOR PCH LLC*

Address: *413 NORTH MCKEAN STREET, KITTANNING, PA, 16201*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *09/28/1987* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *36* **Waking Staff**: *27*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *05/28/2026*

Inspection Dates and Department Representative

05/28/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *43* **Residents Served**: *36*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *23* **Are 60 Years of Age or Older**: *30*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *6*

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

Inspections / Reviews

05/28/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *06/28/2026*

Inspections / Reviews *(continued)*

07/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2026*

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

07/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2026*

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

16c Written Incident Report

1. 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 5/20/2026, an agent from Armstrong County Protective Services was in the home to talk to residents and notified the staff in the home of an allegation that resident #1 was being verbally/physically aggressive towards multiple residents to include resident #2 and stating racial slurs toward minority residents in the home. However, the home did not report the allegation to the Department.

REPEATED VIOLATION - 1/5/26 et al.

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

On 5/28/26, day of inspection, State inspector notified Administrator of the allegation of Resident #1 being verbally/physically aggressive towards multiple other Residents. Administrator unaware of the allegation until Inspectors informed Administrator issued incident report to DHS. on the same day, 5-28-2026. Administrator alerted staff to watch Resident # 1's interaction with others and note any disturbing issues in Tabula pro notes, as well as reporting to Administrator. On Administrator issued a 30 day notice to resident #1 for aggressive behaviors. Resident #1 agreed to see Psychiatrist on . On Administrator contacted Protective services to ask for help with relocation of Resident #1. Beginning day of inspection, all incidents will be monitored and documented as per inspectors recommendation. Training for all staff was held by Executive Director on 6-26-2026 on Reg 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).

This is being disputed due to the fact that the Administrator was unaware of the incident until the day of inspection. The problem was that Armstrong County no longer has an ombudsman. The Ombudsman has always visited the Facility on a regular basis. The 2 Representatives for Protective services started covering the Ombudsman position and had been visiting Residents regularly as the Ombudsman always did. The Administrator was well aware that protective services was in, but thought they were covering the duties of Ombudsman with visiting with the Residents.

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented (- 07/21/2026)

17 Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 11:20 a.m., multiple electronic resident records, to include resident #1, resident #2, resident #3, and resident #4, on

17 Record Confidentiality (continued)

the first floor medication room computer were unlocked accessible and unattended.

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

Administrator closed the computer screen on day of inspection, 5/28/26 when noticed that resident files were visible. Staff training was held on 6 26 2026 by Executive Director with all staff on Reg 2600. 17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure. by Executive Director. Two locking doors were installed by Maintenance Man on 6 8 2026 for the Med room.

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented (- 07/21/2026)

18 - Compliance With Laws

3. 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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil fuel device or appliance." There were no carbon monoxide alarms near the two gas furnaces in the laundry room and storage room of the basement.

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

During walk thru with inspector, it was pointed out that there were 2 missing carbon monoxide detectors. All other areas were checked by Administrator on 5 28 2026. On same day 5 28 2026, Administrator had maintenance man install the 2 required carbon monoxide alarms while Inspectors were still in the building. A walkthrough by Administrator or designated person beginning 7 1 2026 will be done monthly with documentation kept at Facility. On 6 26 2026, Executive Director trained Staff on Regulation 2600. 18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented (- 07/21/2026)

23a - Activities of Daily Living Assistance

4. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

23a Activities of Daily Living Assistance *(continued)*

Description of Violation

The assessment and support plan, dated [redacted] for resident #1 indicated the resident required assistance with irritability, aggression and hallucinations. The home will meet these needs by documenting and reporting changes and notify immediately if any form of hallucination occurs for immediate assessment and treatment. On frequent occasions, resident #1 indicated [redacted] was irritable, aggressive towards residents and had audio hallucinations. However, the resident did not receive assistance as required.

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

On 6 26 2026, Executive Director did training with all staff on Regulation 2600. 23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan. Staff were informed that they need to be observant of all Residents and report any issues to Administration immediately. They were also instructed to use the note option in Tabula Pro to report any needs or observations. Documentation kept at Facility This is being disputed due to Resident #1 receiving assistance anytime Staff knew [redacted] needed it. Resident #1 was the one that reported to State what was going on, and [redacted] does not always get things correct, as it was never brought to the Administrator to assist with.

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented ([redacted] - 07/21/2026)

65g - Annual Training Content

5. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
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 person A did not receive training in the following topics during training year January 1, 2025 to December 31, 2025:

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.

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

Staff person A did not have this required training in 2025. [redacted] is Ancillary and it somehow got neglected. Training was held by Executive Director on 6/26/2026 for staff on Regulation 2600. 65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

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

3. Resident rights.

65g - Annual Training Content (continued)

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

In 2026, All employees are being mandated to take all training .
All previous trainings were reviewed by Administrator on 6-17-2026 to be sure ALL staff including Ancillary have the required trainings. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented (- 07/21/2026)

92 - Windows

6. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

There were no screens in the operable windows in bedrooms #9, #13, and the upstairs office.

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

Bedrooms 9 and 13 both had removable screens in their closets for their windows. The window screens were pulled from closet by Administrator and put by the windows while state inspectors were in the building. On 6-26-2026, Executive director trained all staff on Regulation 2600. 92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open. All other windows were checked by maintenance on 5-28-2026 to be sure they all had screens. Due to the air conditioning, these windows don't get opened.

This is being disputed due to the screens being available for all windows. The regulation pertains to screens being in windows when open. It is an older Victorian home that has screens for all windows, but they are not self storing. This issue happened a few years ago and it was determined by DHS that given the style and age of the home, as long as the screens were available in each room, it was acceptable.

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented (- 07/21/2026)

102i - Soap Dispenser

7. 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

There was an unlabeled used bar of soap in the shared bathroom of resident bedroom #12.

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

Administrator removed bar of soap from bathroom for resident #12 during walk thru with inspector on 5/28/26. A monthly walkthrough by Administrator beginning 7-1-2026 will be done for all rooms to be sure all soap follows

102i - Soap Dispenser (continued)

regulatory compliance. On 6-26-2026, Executive director trained all staff on Regulation 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.
Documentation kept at Facility

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

Implemented ([redacted] - 07/21/2026)

105g - Lint Removal and Duct Cleaning

8. 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 10:30 a.m., there was an approximate 1/4-inch accumulation of lint in both lint traps of the two dryers.

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

Administrator had staff member clean lint trap during walk thru on 5/28/2026. On 6-26-2026, Executive director trained staff on Regulation 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. Administration posted reminder signs to remove lint on 6/1/2026 and a sign off sheet, so Administration can monitor lint removal. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *06/27/2026*

Implemented ([redacted] - 07/21/2026)

132e - Fire Drill Sleeping Hours

9. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 1/14/26 at 4:30 a.m. The previous sleeping hours fire drill was conducted on 6/30/25 at 3:00 a.m.

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

On 6-26-2026, Executive director trained staff on Regulation 2600. 132.e. A fire drill shall be held during sleeping hours once every 6 months. Next overnight fire drill will be done by Administrator in July 2026. It was only a little over a week late due to being lost in the Christmas New Years hustle. A calendar will be created by Executive Director by July 15, 2026 to indicate the dates the drills have to be done by. Documentation kept at Facility.

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

Implemented ([redacted] - 07/21/2026)

132e - Fire Drill Sleeping Hours *(continued)*

187c - Refusal of Medication

10. 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

On 5/2/26, 5/4/26, 5/6/26, 5/7/26, 5/8/26, 5/10/26, 5/11/26, 5/12/26, 5/14/26, 5/16/26, 5/17/26, 5/24/26, & 5/25/26, at bedtime, resident #1 refused to take a scheduled dose of Nystatin 100 unit/gm. The home did not document the refusals in the resident's record nor report the refusals to the prescriber.

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

As per physicians orders the physician is notified if medications were refused more than 3 days. This has been policy with Physician for years. The Physician comes in weekly and is always informed verbally of all refusals for Resident #1. On 6-26-2026 Executive director trained staff on Regulation2600. 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. Resident files were updated by Administrator on 6-26-2026 with signed documentation of physicians orders to be notified after 3 refusals of meds. Documentation kept at Facility

This is being disputed due to the fact that the Physician only wants notified after 3 refusals, which has been in effect for years. There are now signed verifications of these letters in each file, but the physician could verify policy

Licensee's Proposed Overall Completion Date: *06/28/2026*

Implemented ([redacted] - 07/21/2026)

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident #2 was prescribed Clonazepam 1mg tablet, take by mouth three time daily; however, on 5/7/26 at 3:00 p.m. the medication was not administered because the medication was not available in the home.

Resident #4 was prescribed Metformin 500mg, take by mouth twice daily. On 5/8/26 - 5/10/26, & 5/12/26 at 8:00 a.m., and 5:00 p.m., and 5/11/26 & 5/13/26 at 5:00 p.m., the medication was not administered to the resident. The medication was discontinued, in writing by the provider, on 5/14/26.

REPEATED VIOLATION - 6/4/25

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

The medication for Resident #2 was received same day it was needed, but was delivered by Pharmacy 2 hours after administration time.

187d Follow Prescriber's Orders (continued)

Resident #4 does not take Metformin 500mg? On 6 26 2026, Executive director trained all Staff on Regulation 2600. 187.d. The home shall follow the directions of the prescriber. Executive Director talked with med techs, and each one will do MAR audits daily beginning 6 26 2026, with documentation of every audit kept at Facility. This is being disputed due to the directions of the prescriber being followed. The prescriber prescribed the clonazepam to be taken 3 times a day. It was given 3 times on that day, but was 2 hours later due to pharmacy delivery.

Licensee's Proposed Overall Completion Date: *06/28/2026*

Implemented ([redacted] - 07/21/2026)