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

July 28, 2026

[redacted]
WOLF RUN VILLAGE LLC
[redacted]

RE: WOLF RUN VILLAGE
3750 ROUTE 220 HIGHWAY
HUGHESVILLE, PA, 17737
LICENSE/COC#: 22149

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2026, 06/08/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WOLF RUN VILLAGE* **License #**: *22149* **License Expiration**: *07/24/2026*

Address: *3750 ROUTE 220 HIGHWAY, HUGHESVILLE, PA 17737*

County: *LYCOMING* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *WOLF RUN VILLAGE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/12/2009* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *57* **Waking Staff**: *43*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/08/2026*

Inspection Dates and Department Representative

06/02/2026 - On-Site: [redacted]

06/08/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*

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

Have Mobility Need: *2* **Have Physical Disability**: *1*

Inspections / Reviews

06/02/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/04/2026*

Inspections / Reviews *(continued)*

07/28/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

Reviewer: [redacted] **Follow Up Type:** *Bypass Document Submission*

07/28/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

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

Resident [redacted] is prescribed the following medications for administration at 8:00 a.m.: [redacted] *On [redacted], Staff Person A and Resident [redacted] reported that Staff Person A did not administer these medications until approximately 10:00 a.m. The medication error was not reported to the Department.*

Resident [redacted] is prescribed the following medications to be administered at 8:00 a.m.: [redacted] *On [redacted] Staff Person A reports that Staff Person A did not administer these medications to Resident [redacted] until approximately 12:00 p.m. The medication error was not reported to the Department.*

Repeat violation: [redacted] et. al

Plan of Correction ***Accepted 07/28/2026)***

The administrator was informed on the morning of 6/2/26, that the POA for Resident [redacted] had informed a staff member around noon 6/1/26 that Resident [redacted] had not gotten the 8:00 AM meds on 5/31/26 until around 10:00 AM. The DHS representative arrived just after the administrator was informed. The administrator spoke with the resident mid-morning who confirmed the error. Staff Person A stated they arrived at work late that morning and also had an emergency with another resident just before finishing the med pass that caused this pass to be late.

Resident [redacted] was offered meds three times within the hour of administration and refused each time. The meds were documented as refused. A designated person for Resident #[redacted] arrived around lunchtime. Staff Person A informed the designated person of the med refusals and they requested that the meds be administered immediately. Staff Person A did not contact the PCP and offered the meds and the resident took them. Staff Person A then documented the late administration.

The Medication Error Forms were faxed to the PCP and DHS on 6/2/26. (See Attached Reports)

Staff Person A was retrained on the 5 rights of medication administration and reportable incidents on 6/3/26. Staff Person A also acknowledged they understood the importance of arriving at work on time. Staff Person A will only pass meds with a training med tech until the administrator is confident that the staff person is able to complete the pass in a timely manner and understands the requirements of reporting/contacting the Administrator, Resident Designated Person, PCP and DHS.

16c Written Incident Report (continued)

Training on Medication Errors and Incident Reports was completed with All Direct Care Staff on 6/18/26. (See Attached Notes and Training Log)

The administrator will check the AM med passes to ensure they are completed on time for each AM Med Tech for their next three shifts. (See Attached Log)

Licensee's Proposed Overall Completion Date: *07/03/2026*

Implemented [redacted] - 07/28/2026)

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident [redacted] is prescribed the following medications for administration at 8:00 a.m.: [redacted] Staff Person A did not administer these medications until approximately 10:00 a.m.

Resident [redacted] is prescribed the following medications to be administered at 8:00 a.m.: [redacted] Staff Person A did not administer these medications to Resident [redacted] until approximately 12:00 p.m.

Repeat violation: [redacted] et. al

Plan of Correction ***Accept [redacted] - 07/28/2026)***

The administrator was informed on the morning of 6/2/26, that the POA for Resident [redacted] had informed a staff member around noon 6/1/26 that Resident [redacted] had not gotten the 8:00 AM meds on 5/31/26 until around 10:00 AM. The DHS representative arrived just after the administrator was informed. The administrator spoke with the resident mid morning who confirmed the error. Staff Person A stated they arrived at work late that morning and also had an emergency with another resident just before finishing the med pass that caused this pass to be late.

Resident [redacted] was offered meds three times within the hour of administration and refused each time. The meds were documented as refused. A designated person for Resident [redacted] arrived around lunchtime. Staff Person A informed the designated person of the med refusals and they requested that the meds be administered immediately. Staff Person A did not contact the PCP and offered the meds and the resident took them. Staff Person A then documented the late administration.

187d - Follow Prescriber's Orders (continued)

The Medication Error Forms were faxed to the PCP and DHS on 6/2/26. (See Attached Reports)

Staff Person A was retrained on the 5 rights of medication administration and reportable incidents on 6/3/26. Staff Person A also acknowledged they understood the importance of arriving at work on time. Staff Person A will only pass meds with a training med tech until the administrator is confident that the staff person is able to complete the pass in a timely manner and understands the requirements of reporting/contacting the Administrator, Resident Designated Person, PCP and DHS.

Training on Medication Errors and Incident Reports was completed with All Direct Care Staff on 6/18/26. (See Attached Notes and Training Log)

The administrator will check the AM med passes to ensure they are completed on time for each AM Med Tech for their next three shifts. (See Attached Log)

Licensee's Proposed Overall Completion Date: *07/03/2026*

Implemented [redacted] 07/28/2026)

188b - Medication Error Reporting

3. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [redacted] is prescribed the following medications for administration at 8:00 a.m.: [redacted]. On [redacted] Staff Person A did not administer these medications until approximately 10:00 a.m. The medication error was not reported to the resident's designated person and the prescriber.

Resident [redacted] is prescribed the following medications to be administered at 8:00 a.m.: [redacted] Staff Person A did not administer these medications to Resident [redacted] until approximately 12:00 p.m. The medication error was not reported to the resident's designated person and the prescriber.

Repeat violation: [redacted] et. al

Plan of Correction ***Accept [redacted] - 07/28/2026)***

The administrator was informed on the morning of 6/2/26, that the POA for Resident [redacted] had informed a staff member around noon 6/1/26 that Resident [redacted] had not gotten the 8:00 AM meds on 5/31/26 until around 10:00

188b Medication Error Reporting (continued)

AM. The DHS representative arrived just after the administrator was informed. The administrator spoke with the resident mid morning who confirmed the error. Staff Person A stated they arrived at work late that morning and also had an emergency with another resident just before finishing the med pass that caused this pass to be late.

Resident [redacted] was offered meds three times within the hour of administration and refused each time. The meds were documented as refused. A designated person for Resident [redacted] arrived around lunchtime. Staff Person A informed the designated person of the med refusals and they requested that the meds be administered immediately. Staff Person A did not contact the PCP and offered the meds and the resident took them. Staff Person A then documented the late administration.

The Medication Error Forms were faxed to the PCP and DHS on 6/2/26. (See Attached Reports)

Staff Person A was retrained on the 5 rights of medication administration and reportable incidents on 6/3/26. Staff Person A also acknowledged they understood the importance of arriving at work on time. Staff Person A will only pass meds with a training med tech until the administrator is confident that the staff person is able to complete the pass in a timely manner and understands the requirements of reporting/contacting the Administrator, Resident Designated Person, PCP and DHS.

Training on Medication Errors and Incident Reports was completed with All Direct Care Staff on 6/18/26. (See Attached Notes and Training Log)

The administrator will check the AM med passes to ensure they are completed on time for each AM Med Tech for their next three shifts. (See Attached Log)

Licensee's Proposed Overall Completion Date: *07/03/2026*

Implemented [redacted] - 07/28/2026)