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

July 14, 2026

[redacted], OWNER
RUSTIC PROPERTY HOLDINGS LLC
[redacted]

RE: COUNTRYSIDE PERSONAL CARE HOME
1841 STOYSTOWN ROAD
FRIEDENS, PA, 15541
LICENSE/COC#: 33527

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/03/2026 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: *COUNTRYSIDE PERSONAL CARE HOME* **License #**: *33527* **License Expiration**: *11/01/2026*

Address: *1841 STOYSTOWN ROAD, FRIEDENS, PA 15541*

County: *SOMERSET* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *RUSTIC PROPERTY HOLDINGS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/01/2021* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal* **Exit Conference Date**: *06/03/2026*

Inspection Dates and Department Representative

06/03/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *35* **Residents Served**: *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *17*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

06/03/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/26/2026*

06/23/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/23/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/30/2026*

Inspections / Reviews *(continued)*

07/14/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *07/09/2026*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

07/14/2026 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *07/14/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

51 Criminal Background Check

1. 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 A was hired on [redacted] However, a Pennsylvania state police criminal background check was not completed until [redacted]

Repeated Violation - 10/31/24

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The Administrator reviewed hiring procedures with onboarding new hires. A hiring checklist has been revised to require verification that all criminal history clearances are completed and received prior to an employee's first day of work. Personnel files will be audited monthly for compliance.
Monitoring:
The Administrator or designee will review all new hire files prior to the employee's start date and conduct monthly audits of personnel records to ensure ongoing compliance.
Explained to auditor and licensing supervisor that the reason that all documentation was in the chart but the background check was out of date was due to ongoing current audits. When background check was not in chart when auditing, I replaced with a new one. I will continue to audit charts as previous. I was educated by inspector on 6/3/26 regarding timeline of hiring documentation, but this is already in place and why the error was found in the first place.

Proposed Overall Completion Date: 07/09/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 07/14/2026)

89b Hot Water Temperature

2. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 6/3/26 at 1:31 PM, the hot water temperature in the bathroom located on the second floor measured 124.8 degrees Fahrenheit.

On 6/3/26 at 1:39 PM, the hot water temperature in the bathroom located on the first floor measured 124.8 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

Immediately upon identification of the violation, the hot water temperature settings were adjusted. Water temperatures in the first-floor and second-floor resident-accessible bathrooms were rechecked and verified to be at or below 120°F.
Corrective Action:

89b - Hot Water Temperature (continued)

The home's maintenance procedures were reviewed. A monthly water temperature monitoring log has been implemented for all resident-accessible sinks, showers, and tubs to ensure temperatures remain compliant.

Monitoring:
The Administrator or designee will review water temperature logs monthly and address any readings above 120°F immediately.

The day after the inspection the water temperature was adjusted by owner/maintenance. I was educated by inspector on 6/3/26 regarding safety temperature. There was a new valve placed in the past year by our plumbing and heating source and may have made the temperature rise the 4.8 degrees. It is currently reading the 120 degrees. If any thing is touched by heating and plumbing source moving forward, the temperature will be monitored afterward to ensure no change in temperature.

Proposed Overall Completion Date: 07/09/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 07/14/2026)

107d - Procedure Emergency Management Agency Submission

3. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed, updated and submitted to the local emergency management agency (EMA) since 2023.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The home's emergency management plan was reviewed, updated as necessary, and submitted to the local Emergency Management Agency.
Corrective Action:
The Administrator established an annual review schedule to ensure emergency procedures are reviewed, updated, and submitted to the local EMA each year prior to the expiration of the previous review period.

Monitoring:
The Administrator will maintain documentation of annual reviews and EMA submissions and will review compliance annually.

Our most recent 911 coordiantor was [redacted] There was no on to send this to. I was educated by inspector on 6/3/26 that moving forward this could even be sent to our local fire department for review. I will continue to try to make a correct permenant contact to have someone review annualy.

Proposed Overall Completion Date: 07/09/2026

107d Procedure Emergency Management Agency Submission *(continued)*

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 07/14/2026)

125b - Combustible Restrictions

4. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 6/3/26 at 9:16 AM, a propane tank attached to a grill located on the back porch was unlocked, unattended, and accessible to residents.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The propane tank attached to the grill was immediately secured and made inaccessible to residents.
Corrective Action:
All outdoor areas and storage locations were inspected to ensure combustible materials are properly secured. Maintenance removed tank and it will be stored in the locked garage except when using.

Monitoring:
The Administrator or designee will conduct monthly environmental safety rounds to verify combustible materials remain secured and inaccessible to residents.

I was educated on 6/3/26 by inspector that there can not be any compustible material accessable to residents. The tank has been in this same place since 2020, and this is the first time any inspector has cited me for this. I also do not have a community of residents that anyone would ever touch the grill.

Proposed Overall Completion Date: 07/09/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 07/14/2026)

132e - Fire Drill Sleeping Hours

5. 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 5/22/26 at 1:02 AM. The previous sleeping hours fire drill was conducted on 11/5/25 at 4:14 AM.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The home's fire drill schedule was reviewed. A process has been implemented to ensure sleeping hour fire drills are conducted at least once every six months.
Corrective Action:
A fire drill calendar has been established identifying required drill dates, including sleeping hour drills, to ensure

132e - Fire Drill Sleeping Hours (continued)

compliance with regulatory timeframes. This has been used since previous inspection, however was unaware that it had to be 6 months to the day with 5 day grace period. Not 2 in a calendar year.

Monitoring:
The Administrator or designee will review fire drill documentation quarterly to verify required drills have been completed within regulatory requirements.

I was educatd 6/3/26 by the inspector that overnight fire drills must be exactly 6 months apart witha 5 day grace period which I did not know. I have been completing 2 overnight drills within the calendar year, but now understand when they are wanted per regulation.

Proposed Overall Completion Date: 07/09/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 07/14/2026)

183e - Storing Medications

6. Requirements

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

Description of Violation

On 6/3/26, an Incruse Elipta inhaler and an Advair inhaler prescribed for Resident #3, did not contain the date these medications were opened. According to the manufacturer's instructions, both of these medications are to be discarded 6 weeks after opening.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The Incruse Elipta inhaler and Advair inhaler for Resident #3 were immediately labeled with the date opened.
Medication storage practices were reviewed with staff responsible for medication administration.
Corrective Action:
Medication administration staff were re-educated on documenting open dates for medications that require disposal after a specified period. A medication storage audit tool has been implemented to verify medications are labeled and stored according to manufacturer instructions.
Monitoring:
The Administrator or designee will conduct monthly medication storage audits to ensure compliance with manufacturer instructions and regulatory requirements.

Medication cart audits are performed often by myself PCHA/RN with another RN sometimes more than monthly. I was educated by the inspector on 6/3/26 regarding documentation of opening dates and expiration dates which we already follow. This error was the only unmarked item in my cart.

Proposed Overall Completion Date: 07/09/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

183e - Storing Medications *(continued)*

Implemented ([redacted] - 07/14/2026)