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

September 1, 2026

[redacted] SECRETARY/TREASURER
NEW CASTLE AL, LLC
[redacted]

RE: THE ADDISON OF CLEN-MOORE PLACE
22 W. CLEN MOORE BOULEVARD
NEW CASTLE, PA, 16105
LICENSE/COC#: 45508

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/11/2026 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: *THE ADDISON OF CLEN-MOORE PLACE* **License #**: *45508* **License Expiration**: *05/22/2027*

Address: *22 W. CLEN MOORE BOULEVARD, NEW CASTLE, PA 16105*

County: *LAWRENCE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *NEW CASTLE AL, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/05/1997* **Issued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *43* **Waking Staff**: *32*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/11/2026*

Inspection Dates and Department Representative

06/11/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* **Residents Served**: *39*

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**: *39*

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

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

06/11/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2026*

07/10/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/31/2026*

Inspections / Reviews *(continued)*

09/01/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/28/2026*

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

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At approximately 10:40 a.m., an extension cord was damaged and laying across the sidewalk, in the exterior courtyard, posing a trip hazard.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Extension cord was removed immediately on 6/11/2026 by Director of Plant Operations.
2. The Director of Plant Operations was educated on this regulation by the Executive Director on 6/12/2026.
3. Beginning 6/12/2026; Executive Director or Designee will audit the courtyard weekly for 4 weeks and then bi-weekly for 1 month to ensure ongoing compliance
4. The results of audits will be reviewed at Monthly Quality Assurance meetings and continued review will be based on 2 months of sustained compliance. Current Department Directors will be in attendance for QA meetings.

Licensee's Proposed Overall Completion Date: *08/13/2026*

Implemented ([redacted] - 09/01/2026)

100a - Exterior - Free of Hazards

2. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

At approximately 11:15 a.m., a collection of leaves and debris were covering the surface outside the emergency exit door, near room 123.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Leaves were removed immediately on 6/11/2026 by the Director of Plant Operations.
2. The Director of Plant Operations was educated on this requirement on 6/12/2026.
3. Beginning on 6/12/2026; Executive Director or Designee will audit the emergency exit area weekly for 4 weeks and then bi-weekly for 1 month to ensure ongoing compliance
4. The results of audits will be reviewed at Monthly Quality Assurance meetings and continued review will be based on 2 months of sustained compliance. Current Department Directors will be in attendance for QA meetings.

Licensee's Proposed Overall Completion Date: *08/13/2026*

Implemented ([redacted] - 09/01/2026)

101j5 - Bedside Table/Shelf

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

At approximately 10:10 a.m., the bed belonging to resident #1 did not have a bedside table or shelf.

101j5 - Bedside Table/Shelf *(continued)*

Plan of Correction ***Accept (- 07/10/2026)***

1. The Director of Plant Operations immediately placed the bedside table beside the bed on 6/11/2026.
2. Current staff will be educated on this regulation by 7/16/2026.
3. The private duty care giver who removed the bedside table was educated on this regulation on 6/12/2026 by the Executive Director.
4. Current rooms were audited pursuant to this regulation on 6/12/2026 by the Director of Plant Operations, no additional findings were found.
5. Beginning on 6/19/2026; Current rooms will continue to be audited weekly for two months by Executive Director or Designee.
6. The results of audits will be reviewed at Monthly Quality Assurance meetings and continued review will be based on 2 months of sustained compliance. Current Department Directors will be in attendance for QA meetings.

Licensee's Proposed Overall Completion Date: *08/24/2026*

Implemented (- 09/01/2026)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At approximately 10:10 a.m., the bed belonging to resident #1 did not have a source of lighting that can be turned on/off from bedside.

At approximately 11:00 a.m., the bed belonging to resident #2 did not have a current source of lighting, as the lightbulb was not functioning resulting in the inoperable lamp.

Repeated Violation- 06/05/2025

Plan of Correction ***Accept (- 07/10/2026)***

1. The Director of Plant Operations immediately placed the lamp beside the bed on 6/11/2026 for Resident #1.
2. The Director of Plant Operations immediately changed the light bulb on 6/11/2026 for Resident #2
3. The private duty care giver who removed the bedside lamp for Resident #1 was educated on this regulation on 6/12/2026 by the Executive Director.
4. Current staff will be educated on this regulation by 7/16/2026.
5. Current resident rooms were audited pursuant to this regulation on 6/12/2026 by the Director of Plant Operations. No additional violations were found.
6. Beginning on 6/19/2026; Current resident rooms will continue to be audited weekly for two months.
7. The results of audits will be reviewed at Monthly Quality Assurance meetings and continued review will be based on 2 months of sustained compliance. Current Department Directors will be in attendance for QA meetings.

Licensee's Proposed Overall Completion Date: *08/24/2026*

Implemented (- 09/01/2026)

132d - Evacuation

5. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's Fire Evacuation Time/Fire Safe Area Designation Form completed by a fire safe expert, dated 9/30/25, indicated the home has fire safe areas "Beyond the automatic doors, in the halls gathering by the exit doors, this also includes the front area, and to the outside of the building, there are 4 fire safe areas. However, Multiple staff and resident interviews indicated residents who are not located in the simulated fire zone, at the time of a fire drill, remain in their bedrooms during fire drills, to include the fire drill help on 3/17/26 at 4:14 a.m. Additionally, the home's fire drill policy indicated "staff in other zones should calm resident, let them know it's only a drill, and close the doors until the drill is over."

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The inaccurate fire drill policy that was posted was immediately removed and revised on 6/11/2026. The revised posting states: the identified affected area will be evacuated first and then staff will ensure residents in non-affected areas exit their rooms, remain ready for possible evacuation and await further instructions.
2. Current staff were educated on this regulation on 6/15/2026 by the Executive Director, referencing page 197-198 in the RCG. The Executive Director maintains the required training by the Fire Safety Expert to complete this training.
3. Current residents were educated on this requirement by the Executive Director on 6/16/2026.
4. Beginning on 6/30/2026; Compliance will be monitored by the Executive Director or Designee during monthly fire drills and will be determined by 3 months of continued compliance. Results will be discussed during monthly Quality Assurance Regulations. Current Department Directors will be in attendance for QA meetings.

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

Implemented ([redacted] - 09/01/2026)

225c - Additional Assessment

6. 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.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's annual assessment, dated [redacted] was blank in the agitation section; however, the plan to meet this need indicated this resident has a history of becoming agitated and DCS will assist and attempt to redirect as needed.

Repeated Violation- 06/05/2025

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The Health and Wellness Director was educated on this regulation by the Executive Director on 6/11/2026.
2. A significant change RASP was completed by the Health and Wellness Director on 6/12/2026, during this the

225c - Additional Assessment (continued)

agitation section was selected as (B), to reflect that the resident has a history of agitation. This RASP was signed by the resident.
3. The Executive Director reviewed the significant change RASP on 6/12/2026 to ensure compliance with this regulation.
4. Beginning on 6/30/2026, Current RASPs will be audited to verify accuracy that reflects the resident's current needs by the HWD or designee. This audit will be reviewed by the Executive Director. Any RASPs requiring an update will be completed to reflect the current needs of the resident. This will be completed by 7/31/2026.
5. Any new admissions, readmissions, or significant change RASP will be reviewed by the Executive Director to verify the accuracy of the residents needs.
6. The results of audits will be reviewed at Monthly Quality Assurance meetings and continued review will be based on 3 months of sustained compliance. Current Department Directors will be in attendance for QA meetings.

Licensee's Proposed Overall Completion Date: *08/17/2026*

Implemented ([redacted] - 09/01/2026)

227c - Support Plan Revision

7. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1's annual support plan, dated [redacted] indicated this resident requires some physical assistance with toileting, personal hygiene, was able to self-ambulate with use of a wheeled walker, was able to self-transfer, and turn and reposition in bed/chair independently. However, the residents care needs have increased. Interviews and records indicated this resident uses a wheelchair for ambulation, is unable to self-transfer alone and was an assist of 2 persons. The support plan was blank, under the Judgement section, even though the assessment indicated minimal problem. Additionally, the name of the agency and their contact information was not updated on the support plan.
Resident #2's bedroom is equipped with a hospital bed, a mattress with built-in guards for fall prevention, a fall mat next to the bed, and a wedge pillow. However, the support plan, dated [redacted], did not address the plan to meet this residents need, who would be responsible for monitoring these items, and the frequency.

Repeated Violation- 06/05/2025

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The Health and Wellness Director was educated on this regulation by the Executive Director on 6/11/2026.
2. A significant change RASP was completed by the Health and Wellness Director on 6/12/2026 for Resident #1, during this the RASP was changed to reflect that the resident uses a wheelchair for ambulation, requires assistance with 2 persons for transfers, the judgement section was revised to indicate that resident may require assistance with judgement and that DCS will provide assistance to ensure that decisions are safe for [redacted] and others. The Agency name has been updated on the support plan.
3. The Health and Wellness Director completed a RASP addendum on 6/12/26 for resident #2, indicating the need and presence of a hospital bed, mattress with bolsters for fall prevention, fall mat, and wedge pillow as well as the need for DCS to monitor these items daily for safety.

227c - Support Plan Revision (continued)

4. The Executive Director reviewed the significant change RASP for Resident #1 and the Addendum for Resident #2 on 6/12/2026 to ensure compliance with this regulation.
5. Beginning on 6/30/2026, Current RASPs will be audited to verify accuracy that reflects the resident's current needs by the HWD or designee. This audit will be reviewed by the Executive Director. Any RASPs requiring an update will be completed to reflect the current needs of the resident. This will be completed by 7/31/2026.
6. Any new admissions, readmissions, or significant change RASP will be reviewed by the Executive Director to verify the accuracy of the residents needs.
7. The results of audits will be reviewed at Monthly Quality Assurance meetings and continued review will be based on 3 months of sustained compliance. Current Department Directors will be in attendance for QA meetings.

Licensee's Proposed Overall Completion Date: *08/17/2026*

Implemented ([redacted] - 09/01/2026)