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

August 26, 2026

[redacted], OWNER
DUNLEVY MANOR LIVING LLC
2218 PA-88
DUNLEVY, PA, 15432

RE: RIVERSIDE MANOR LLC
2218 PA-88
DUNLEVY, PA, 15432
LICENSE/COC#: 45597

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/01/2026 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: *RIVERSIDE MANOR LLC* **License #**: *45597* **License Expiration**: *09/23/2026*

Address: *2218 PA 88, DUNLEVY, PA 15432*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *DUNLEVY MANOR LIVING LLC*

Address: *2218 PA-88, DUNLEVY, PA, 15432*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/01/2026*

Inspection Dates and Department Representative

07/01/2026 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *11*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *11*

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

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

07/01/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/09/2026*

08/07/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/21/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/12/2026*

Inspections / Reviews *(continued)*

08/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/21/2026*

08/26/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2026*

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

23a - Activities of Daily Living Assistance

1. Requirements

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

Description of Violation

Resident #2's assessment completed [redacted], indicates that resident's Mobility Assessment is Total (Immobile). The resident's support plan indicates the plan to meet the mobility needs is that "Two staff members will assist resident #2 with all transfers including in the event of an evacuation and/or emergency. Resident #2 will be transferred by using a hoyer lift. [redacted] will be transferred into [redacted] wheelchair." However, staff interviews indicate that staff are not regularly using a hoyer lift to transfer resident #2. Staff are placing one staff person on each side of the resident using a manual transfer method.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Violation:
Resident #2's assessment completed on [redacted], identifies the resident as totally immobile. The resident's support plan states that two staff members are to assist with all transfers using a Hoyer lift, including during emergencies and evacuations. Staff interviews revealed that staff were routinely performing manual two-person transfers instead of utilizing the Hoyer lift as required by the resident's assessment and support plan.

Immediate Corrective Action

Date Completed: August 6, 2026

Immediately upon discovery of the violation, all direct care staff were instructed to discontinue manual transfers of Resident #2. The resident's support plan was reviewed with all staff currently providing care, and the resident was immediately returned to being transferred exclusively with the Hoyer lift by two trained staff members in accordance with the assessment and support plan. The Administrator verified that the Hoyer lift was available, functioning properly, and accessible for use.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted a mandatory staff meeting with all direct care staff. Education included:

Reviewing Resident #2's assessment and support plan.
Reinforcing that all transfers for Resident #2 must be completed using the Hoyer lift with two staff members.
Reinforcing the requirement that staff follow each resident's assessment and support plan without deviation unless updated by the appropriate healthcare professional.
Reviewing the importance of using approved transfer equipment to ensure resident safety and prevent injury.
Explaining that failure to follow resident care plans and facility policies may result in disciplinary action.

Any staff unable to attend the meeting will receive one-on-one education before returning to direct resident care.

23a Activities of Daily Living Assistance (continued)

Compliance Monitoring

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Administrator and/or designee will conduct random observations of Resident #2's transfers to ensure the Hoyer lift is being used in accordance with the resident's assessment and support plan. Monitoring will occur:

Weekly for four (4) weeks.
Monthly for the following three (3) months.

Documentation of all observations will be maintained. Any deficiencies identified during monitoring will be addressed immediately through corrective coaching, re education, and disciplinary action when warranted. Monitoring records will be retained by the facility and reviewed to ensure ongoing compliance with resident transfer requirements and applicable regulations.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented (- 08/26/2026)

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.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff person A, hired and staff person B, hired did not receive annual training by a fire safety expert during the 1/1/25 to 12/31/25 staff training year.

Staff person A, hired and staff person B, hired did not receive training that addressed the Older Adult Protective Services Act (35 P.S §§ 10225.101 10225.5102) and mandatory reporting during the 1/1/25 to 12/31/25 staff training year.

Plan of Correction ***Accept (- 08/18/2026)***

Violation

Staff Person A (hire date:) and Staff Person B (hire date:) did not receive the required annual training by a fire safety expert during the January 1, 2025, through December 31, 2025, training year. In addition, Staff Person A and Staff Person B did not receive the required annual training on the Older Adult Protective Services Act (OAPSA) and mandatory reporting during the January 1, 2025, through December 31, 2025, training year.

65g - Annual Training Content (continued)

Immediate Corrective Action

Date Completed: August 6, 2026

On 7/2/2026 upon identification of the deficiency, the Supervisor immediately reviewed all staff training records to verify the missing annual training requirements for Staff Person A and Staff Person B. On August 6, 2026, the Administrator provided both staff members with education on the Older Adult Protective Services Act (OAPSA) and mandatory reporting requirements. Documentation of the completed training was placed in each employee's personnel file.

The facility also contacted the local Fire Chief on August 5, 2026, to schedule the required annual fire safety training by a qualified fire safety expert for Staff Person A and Staff Person B. Upon completion, documentation of the fire safety training will be maintained in each employee's training file.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted a staff training reviewing all required annual education topics, including the Older Adult Protective Services Act, mandatory reporting requirements, and annual fire safety training requirements. Staff were educated on the importance of completing all mandatory annual training within the required training year.

The Supervisor implemented a training tracking system to monitor annual education requirements for all employees. The training log will identify due dates for mandatory education, and reminders will be issued prior to expiration to ensure all required training is completed on time.

Compliance Monitoring

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Supervisor and/or Administrator will audit employee training records on a monthly basis for the next three (3) months to ensure all mandatory annual training requirements are completed and documented. Thereafter, training records will be reviewed quarterly to verify continued compliance.

Any employee identified as missing required training will be scheduled for education immediately and will not be permitted to remain out of compliance. Documentation of all audits, completed training, and corrective actions will be maintained by the facility for review to ensure ongoing compliance with state regulations.

Licensee's Proposed Overall Completion Date: *08/18/2026*

Implemented ([redacted] - 08/26/2026)

85a - Sanitary Conditions

3. Requirements

2600.

85a - Sanitary Conditions *(continued)*

85.a. Sanitary conditions shall be maintained.

Description of Violation

At 10:11 a.m., there were miscellaneous dried-on food drips and splashes on the front of the lower cabinets under and to the left of the stove in the kitchen.

At 10:11 a.m., there were black and brown crumbs and smears stuck on the bottom of the inside of the lower cabinet to the right of the sink in the kitchen.

There was brown and black crumbs and grime along the inside front edge of the corner cabinet that stores pots and pans in the kitchen.

Plan of Correction ***Accept (- 08/07/2026)***

Violation

At approximately 10:11 a.m., miscellaneous dried-on food drips and splashes were observed on the front of the lower cabinets under and to the left of the stove in the kitchen. Black and brown crumbs and smears were observed on the bottom inside of the lower cabinet to the right of the sink. Brown and black crumbs and grime were also observed along the inside front edge of the corner cabinet used to store pots and pans. These conditions did not meet the home's standards for maintaining a clean and sanitary kitchen environment.

Immediate Corrective Action

Date Completed: July 2, 2026

On July 2, 2026, the Cook immediately completed a thorough cleaning and sanitizing of all affected kitchen cabinets and surrounding surfaces. The cleaning was directly overseen and inspected by the Supervisor to ensure all food residue, crumbs, grease, and grime were removed and that the kitchen was restored to sanitary condition.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted mandatory staff education regarding proper kitchen sanitation, infection prevention, cleaning expectations, and maintaining a sanitary food preparation environment. Staff were instructed on the importance of routinely cleaning cabinet interiors and exteriors, food storage areas, and all kitchen surfaces to prevent the accumulation of food debris and grime.

Beginning August 3, 2026, the Cook will complete documented kitchen sanitation inspections three (3) times per week to verify that all kitchen cabinets, storage areas, and food preparation surfaces remain clean and sanitary. These inspections will be reviewed and overseen by the Supervisor.

Compliance Monitoring

Monitoring Begins: August 3, 2026

85a - Sanitary Conditions (continued)

Beginning August 3, 2026, the Supervisor will review the Cook's sanitation inspection logs three (3) times per week and conduct random inspections of the kitchen to verify continued compliance with sanitation standards. Monitoring will continue for 90 days. Any deficiencies identified during inspections will be corrected immediately, documented, and addressed through additional staff education or corrective action as appropriate. All monitoring documentation will be maintained by the facility to ensure ongoing compliance with state regulations and the home's sanitation policies.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented ([redacted] - 08/26/2026)

90b - Staff Communication

4. Requirements

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home currently serves 11 residents. However, the home has no system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Violation

The home currently serves 11 residents. However, the home did not have a system or method of communication that enabled staff persons to immediately contact other staff persons in the home for assistance during an emergency.

Immediate Corrective Action

Date Completed: August 4, 2026

Upon identification of the deficiency, the Supervisor notified the Owner of the need for an immediate staff communication system. On August 4, 2026, the Owner ordered walkie-talkies to provide staff with an immediate and reliable method of communication throughout the facility. The Supervisor verified that the communication devices would be made available for staff use upon receipt.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted mandatory staff education on the proper use of the walkie-talkies, including when and how to communicate during emergencies, resident assistance, and routine operations requiring immediate staff response. Staff were instructed that walkie-talkies are to be carried during each shift and kept readily available to ensure prompt communication between staff members at all times.

The facility has updated its procedures to require the use of the walkie-talkie communication system during all shifts to ensure staff can immediately request assistance in the event of an emergency or resident care need.

90b - Staff Communication (continued)

Compliance Monitoring

Monitoring Begins: August 10, 2026

Beginning August 10, 2026, the Supervisor will monitor staff compliance with the walkie-talkie communication system during daily rounds and routine shift observations. The Supervisor will verify that communication devices are present, operational, and being used appropriately by staff on every shift.

Compliance will be monitored weekly for four (4) weeks and monthly thereafter for three (3) months. Any staff found not utilizing the communication system as required will receive immediate re-education and corrective action as appropriate. Documentation of all monitoring activities and any corrective measures will be maintained by the facility to ensure ongoing compliance with regulatory requirements.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented ([redacted] - 08/26/2026)

95 - Furniture and Equipment

5. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At 10:15 a.m., there was no drawer front on the drawer to the right of the sink in the home's kitchen. The corner base cabinet does not close completely.

At 12:45 p.m., there was no functioning sink in the staff bathroom. The faucet was simply setting on the sink top; it was not installed nor hooked up to water. There was no means to wash hands.

Plan of Correction ***Accept ([redacted] - 08/18/2026)***

Violation

At 10:15 a.m., there was no drawer front on the drawer to the right of the sink in the home's kitchen, and the corner base cabinet did not close completely. At 12:45 p.m., the staff bathroom sink was not functioning. The faucet was sitting on top of the sink and was neither installed nor connected to a water source, resulting in no means for staff to wash their hands.

Immediate Corrective Action

Date Completed: August 6, 2026

On 7/2/2026 the Supervisor immediately assessed the affected areas and notified the Maintenance [redacted] of the necessary repairs. Staff were instructed to utilize an alternate functioning handwashing sink within the facility until the staff bathroom sink is repaired to ensure proper hand hygiene was maintained at all times. The Supervisor verified that an alternate handwashing station was readily available and accessible to staff.

95 Furniture and Equipment (continued)

Education

The administrator provided education on 8/6/2026 to the staff regarding the monitoring and reporting of building repairs. The supervisor was instructed to conduct regular checks of the building and identify any repairs or maintenance needs. Any repairs identified must be documented and reported to the maintenance person within 24 hours to ensure timely completion and continued compliance with the Plan of Correction.

Permanent Corrective Action

Date Initiated: August 6, 2026

The kitchen is currently scheduled for renovation by the maintenance [redacted] The Maintenance [redacted] will complete the following repairs as part of the renovation project:

Replace the missing drawer front to the drawer located to the right of the kitchen sink.
Repair or replace the corner base cabinet so it closes properly.
The maintenance [redacted] Installed and connected the staff bathroom sink faucet on 7/31/2026 to restore a fully functioning handwashing sink.

The renovation project will begin as soon as all required materials and supplies are delivered and will be completed within sixty (60) days. The Supervisor will oversee the progress of the repairs to ensure all deficiencies are corrected in a timely manner.

Compliance Monitoring

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Supervisor will monitor the progress of the renovation and repair project on a weekly basis until all work has been completed. Upon completion, the Supervisor will conduct inspections to verify that all cabinets are in good repair and that the staff bathroom sink is fully operational and available for proper handwashing.

All repair work, inspections, renovation progress, and follow up reviews will be documented and maintained by the facility. Any additional maintenance concerns identified during monitoring will be addressed promptly to ensure continued compliance with state regulations and the home's maintenance standards.

Licensee's Proposed Overall Completion Date: *08/18/2026*

Implemented ([redacted] - 08/26/2026)

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

103f Refrigerator/Freezer Temps *(continued)*

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 11:20 a.m., the top freezer section of the white refrigerator/freezer in the home's kitchen measured 18 degrees Fahrenheit. At 5:00 p.m., it still measured 18 degrees Fahrenheit.

Repeated violation 6/25/25

Plan of Correction ***Accept (- 08/07/2026)***

Violation

At 11:20 a.m., the top freezer section of the white refrigerator/freezer in the home's kitchen measured 18°F. At 5:00 p.m., the freezer temperature remained at 18°F, indicating the freezer was not maintaining the required temperature for safe food storage.

Immediate Corrective Action

Date Completed: July 2, 2026

Upon identification of the deficiency, the Supervisor immediately assessed the freezer and arranged for corrective action. On July 2, 2026, the old thermostat was replaced with a new thermostat to restore the freezer to proper operating temperature. The Supervisor verified that the freezer was functioning properly following the repair and that food storage temperatures returned to acceptable ranges.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted mandatory staff training regarding proper food storage, freezer temperature requirements, temperature monitoring procedures, and actions to take if temperatures fall outside acceptable ranges. Staff were educated by the Supervisor on the importance of maintaining appropriate freezer temperatures and documenting temperature checks accurately to ensure food safety and regulatory compliance.

Compliance Monitoring

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Cook will check and document the freezer temperature daily to ensure temperatures remain within regulatory requirements. The Supervisor will review the temperature logs on a regular basis and verify that any temperature concerns are addressed immediately.

The Supervisor will conduct weekly audits of the temperature logs for four (4) weeks, followed by monthly reviews for three (3) months to ensure continued compliance. Any deficiencies identified during monitoring will be corrected immediately through additional staff education and corrective action as necessary.

All documentation, including daily temperature logs, training records, monitoring audits, maintenance records, and

103f - Refrigerator/Freezer Temps (continued)

any corrective actions taken, will be maintained by the facility to demonstrate ongoing compliance with state regulations.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented ([redacted] - 08/26/2026)

132b - Safety Inspection/Fire Drill

7. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection and supervised fire drill was completed 8/22/25. However, the previous fire safety inspection and supervised fire drill was completed 7/19/24.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Violation

The home's most recent fire safety inspection and supervised fire drill were completed on August 22, 2025. However, the previous fire safety inspection and supervised fire drill were completed on July 19, 2024, resulting in the required annual fire safety inspection and supervised fire drill not being completed within the required timeframe.

Immediate Corrective Action

Date Completed: August 6, 2026

Upon identification of the deficiency, the Supervisor immediately reviewed the facility's fire safety records and confirmed the lapse in the scheduling of the annual fire safety inspection and supervised fire drill. A fire safety calendar was reviewed and updated to ensure future inspections and supervised fire drills are scheduled and completed within the required regulatory timeframes. The Supervisor also verified that all current fire safety documentation was organized and maintained in the facility's fire safety records.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted mandatory staff education regarding the importance of completing annual fire safety inspections and supervised fire drills within the required timeframes. Staff were educated on their roles during fire drills, emergency preparedness, documentation requirements, and the importance of maintaining compliance with all fire safety regulations.

The Supervisor implemented a tracking system that includes advance reminders and scheduled due dates for all required annual fire safety inspections and supervised fire drills to prevent future lapses.

Compliance Monitoring

132b - Safety Inspection/Fire Drill (continued)

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Supervisor will review the facility's fire safety compliance calendar and documentation monthly to ensure all required fire safety inspections and supervised fire drills are scheduled and completed before their due dates. The Administrator will also review the documentation during routine administrative audits to verify ongoing compliance.

All documentation, including fire safety inspection reports, supervised fire drill records, training attendance sheets, monitoring logs, and any corrective actions taken, will be maintained by the facility and made available for review to demonstrate continued compliance with state regulations.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented ([redacted] - 08/26/2026)

183e - Storing Medications

8. 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

At 2:53 p.m., there was a bottle of refresh tear drops 0.5% with pharmacy label for resident #1 that indicated - instill 1 or 2 drops into affected eye (s) as needed. The bottle was not dated when opened.

Plan of Correction ***Accept ([redacted] - 08/07/2026)***

Violation

At 2:53 p.m., there was a bottle of Refresh Tear Drops 0.5% with a pharmacy label for Resident #1 directing staff to instill one or two drops into the affected eye(s) as needed. The bottle was not dated when it was opened, resulting in the facility being unable to verify the medication's expiration after opening.

Immediate Corrective Action

Date Completed: July 1, 2026

Upon identification of the deficiency, the Supervisor immediately removed the undated bottle of Refresh Tear Drops from service and properly discarded it on July 1, 2026. A new bottle was ordered and placed into service on July 1, 2026, and it was dated appropriately upon opening in accordance with facility policy and manufacturer recommendations.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator provided mandatory education to all medication administration staff regarding proper medication labeling procedures, including the requirement to date all medications, eye drops,

183e Storing Medications (continued)

insulin, creams, and other multi dose items immediately upon opening. Staff were instructed on the importance of dating medications to ensure medication integrity, resident safety, and regulatory compliance.

The Supervisor reinforced the facility's medication storage and labeling policy and instructed staff that all newly opened medications must be dated immediately at the time they are opened.

Compliance Monitoring

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Supervisor will conduct weekly medication cart and medication storage audits for four (4) weeks, followed by monthly audits for three (3) months, to verify that all medications requiring an opened date are properly labeled.

Any deficiencies identified during the audits will be corrected immediately through re education and corrective action as appropriate. The Supervisor will review all findings to ensure continued compliance with medication management requirements.

All documentation, including training attendance records, medication audit forms, monitoring logs, and corrective actions taken, will be maintained by the facility to demonstrate ongoing compliance with state regulations and facility policy.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented ([redacted] - 08/26/2026)

190a - Completion Medication Course

9. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

A Medication Administration Training Course Summary and Requalification form was not completed for staff person A for 2026. The most recent annual practicum completed for staff person A was 3/26/25. However, staff person A administered medications to residents #1, #2 and #3 on the following dates to include: 6/1 6/4/26, 6/6 6/11/26, 6/13/26, 6/15 6/18/26, 6/20/26, 6/22 6/25/26, 6/27/26, 6/29/26 and 6/30/26.

The most recent annual practicum completed and signed by a Train the Trainer for staff person B was on 3/26/25. The staff person's 2026 observations and MAR reviews completed by a practicum observer do not include a Summary and Requalification form signed by a Train the Trainer indicating staff person B has been requalified. However, staff person B administered medications to residents #1, #2 and #3 on the following dates to include: 6/1/26, 6/2/26, 6/3/26, 6/6/26, 6/8/26, 6/9/26, 6/10/26, 6/11/26, 6/15/26, 6/16/26, 6/17/36, 6/18/26, 6/22/26, 6/23/26, 6/24/26, 6/25/26, 6/29/26 and 6/30/26.

Staff person C has not completed the Standard Medication Administration Training Course offered by The Office of

190a - Completion Medication Course (continued)

Developmental Programs. Staff person C completed the Modified Medication Administration Training Course on 5/1/25. However, staff person C administered medications to residents #1, #2 and #3 on the following dates to include: 6/5/26, 6/12/26, 6/14/26, 6/19/26, 6/21/26, 6/26/26, 6/27/26, and 6/28/26.

Plan of Correction ***Accept (- 08/07/2026)***

Violation

The facility failed to ensure medication administration qualifications were current and properly documented.

Staff Person A did not have a completed Medication Administration Training Course Summary and Requalification Form for 2026. The most recent annual practicum was completed on March 26, 2025. Despite the missing documentation, Staff Person A administered medications to Residents #1, #2, and #3 on multiple dates during June 2026.
Staff Person B completed the required 2026 observations and MAR reviews; however, the Medication Administration Training Course Summary and Requalification Form was not signed by a certified Train-the-Trainer to indicate requalification. The most recent annual practicum was completed on March 26, 2025. Staff Person B administered medications to Residents #1, #2, and #3 on multiple dates during June 2026.
Staff Person C had not completed the Standard Medication Administration Training Course offered by the Office of Developmental Programs. Staff Person C had only completed the Modified Medication Administration Course on May 1, 2025, yet administered medications to Residents #1, #2, and #3 on multiple dates during June 2026.
Immediate Corrective Action

Date Completed: July 2, 2026

Upon identification of the deficiencies, the Supervisor immediately reviewed all medication administration training records and staff qualifications.

As directed by state officials, the certified Medication Administration Train-the-Trainer reviewed the documentation for Staff Person A and Staff Person B. The Medication Administration Training Course Summary and Requalification Forms were completed to reflect the April 13, 2026 requalification date and were signed and dated by the certified Medication Administration Train-the-Trainer on July 2, 2026.

For Staff Person C, the Administrator had previously provided access to complete the required Standard Medication Administration Training Course. Staff Person C failed to complete the required training within the required timeframe. Effective July 2, 2026, Staff Person C was immediately removed from all medication administration duties and is no longer permitted to administer medications until all required training has been successfully completed and documented.

Preventative Action

Date Completed: August 6, 2026

On August 6, 2026, the Administrator conducted mandatory education with all medication administration staff regarding Pennsylvania medication administration training requirements, annual practicum requirements, requalification documentation, and the requirement that no employee may administer medications unless all required education, competency evaluations, and Train-the-Trainer documentation are complete and current.

190a - Completion Medication Course (continued)

The Supervisor implemented a medication certification tracking system to monitor all medication administration credentials, annual practicum due dates, requalification forms, and required training. The tracking system includes advance reminders to ensure all documentation is completed before expiration. Staff will not be scheduled to administer medications if required qualifications or documentation are incomplete.

Compliance Monitoring

Monitoring Begins: August 6, 2026

Beginning August 6, 2026, the Supervisor will review all medication administration personnel files monthly to verify that medication administration certifications, annual practicums, observation forms, MAR reviews, and Medication Administration Training Course Summary and Requalification Forms are complete, current, and properly signed before staff are assigned medication administration duties.

The Administrator will also conduct quarterly audits of medication administration records and employee training files to ensure continued compliance with state regulations. Any deficiencies identified will be corrected immediately through re-education, completion of required documentation, removal from medication administration duties when appropriate, and corrective action as necessary.

All documentation, including medication administration training records, practicum documentation, requalification forms, training attendance sheets, audit results, monitoring logs, and corrective actions taken, will be maintained by the facility to demonstrate ongoing compliance with state regulations.

Licensee's Proposed Overall Completion Date: *08/06/2026*

Implemented ([redacted] - 08/26/2026)