

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

October 8, 2026

[REDACTED], RCC
ST PAUL HOMES
339 EAST JAMESTOWN ROAD
GREENVILLE, PA, 16125

RE: THE HERITAGE AT ST. PAUL HOMES
339 EAST JAMESTOWN ROAD
GREENVILLE, PA, 16125
LICENSE/COC#: 42457

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/08/2026, 07/09/2026 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 HERITAGE AT ST. PAUL HOMES **License #:** 42457 **License Expiration:** 07/02/2027
Address: 339 EAST JAMESTOWN ROAD, GREENVILLE, PA 16125
County: MERCER **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: ST PAUL HOMES
Address: 339 EAST JAMESTOWN ROAD, GREENVILLE, PA, 16125
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 05/31/2006 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 122 **Waking Staff:** 92

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint, Incident **Exit Conference Date:** 07/09/2026

Inspection Dates and Department Representative

07/08/2026 - On-Site: [REDACTED]

07/09/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 125 **Residents Served:** 82

Secured Dementia Care Unit

In Home: Yes **Area:** Serenity Lane **Capacity:** 49 **Residents Served:** 38

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 82
Diagnosed with Mental Illness: 8 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 40 **Have Physical Disability:** 0

Inspections / Reviews

07/08/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 08/07/2026

08/20/2026 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 09/11/2026
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 08/27/2026

Inspections / Reviews (*continued*)

09/01/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/11/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/11/2026

10/08/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/11/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a Resident Abuse Report

1. Requirements

2600.

15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701 10225.707) and 6 Pa. Code § 15.21 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 6/26/26 at approximately 12:30 p.m., direct care staff A and direct care staff B were providing toileting assistance to resident #1 when the resident became verbally agitated and physically aggressive. Direct care staff A did not follow the resident's support plan to provide space. Rather, direct care staff A utilized physical prompting on the resident's hips and shoulders in progressively increasing force to move the resident onto the toilet. Once on the toilet, direct care staff A held the resident's wrists to prevent the resident from striking the staff, causing the resident to state "Ow! You're hurting me!" This allegation of abuse was not immediately reported in accordance with the Older Adult Protective Services Act until 4:00 p.m. on 6/26/26.

Plan of Correction

Accept () - 09/01/2026)

Immediate Action—The team member who reported the suspected abuse was not immediately available for re-education after this violation was identified. () was educated by this Administrator on 7/29/2026 with a complete review of the regulation and what () did incorrectly in this specific situation. The administrator also provided specific situational examples of "possible situations" where () would need to report immediately and what that would look like in that situation.

This team member was trained on this with () Temple Direct Care Training and Competency Test on 3/13/2026. () was also trained on abuse and neglect by the Administrator in () initial training on 3/10/26 and again on 5/12/26. This employee is a college student who started () onboarding with us on Spring Break and then came back at the end of the semester; this is why it was reviewed twice.

This Administrator believes that we do not have a problem with following the regulation; we had a new, young team member who became upset and didn't utilize () training within the appropriate timeline. This is not to blame the employee, but to mention that sometimes in urgent situations we can become overwhelmed and not recall our training. This was also discussed with the team member when () was re-educated on 7/29/26.

Changing practice, teaching, and ongoing monitoring—(position of who will be monitoring)

This regulation will be reviewed with all staff at the September staff meeting.

We are continuing to teach/educate about abuse and neglect upon hire and annually. We are adding an additional training this year for all staff to complete via Relias.

This Administrator has reached out to the Ombudsman to see what additional abuse training the Area Agency on Aging can provide to our staff. Waiting to hear back from () at this time.

Designate responsibility and specific target dates for correction—

Administrator, 7/29/26 and ongoing.

Evidence of compliance—

Attached in Sans Write are the Temple training, initial training, and re-education for C. Wright regarding this regulation.

Licensee's Proposed Overall Completion Date: 08/27/2026

Implemented () - 10/08/2026)

42c Treatment of Residents

2. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #1's most recent assessment and support plan, dated [REDACTED] indicates that resident #1 can become irritable and upset/agitated at times without provocation and staff will redirect, distract and walk away when needed to allow resident space. However, according to multiple staff interviews, on 6/26/26 at approximately 12:30 p.m., direct care staff A and direct care staff person B were providing toileting assistance to resident #1 when the resident became verbally agitated and physically aggressive. Direct care staff A did not follow the resident's support plan to provide space. Rather, direct care staff A utilized physical prompting on the resident's hips and shoulders in progressively increasing force to move the resident onto the toilet. Once on the toilet, direct care staff A held the resident's wrists to prevent the resident from striking the staff, causing the resident to state "Ow! You're hurting me!"

Plan of Correction

Accept [REDACTED] - 09/01/2026)

Immediate Action— The team member who did not treat our residents respectfully was terminated. We will not tolerate any mistreatment of our residents.

****The incident where this occurred was before the state visit on 7/8/2026****

Changing practice, teaching, and ongoing monitoring—(position of who will be monitoring)

This regulation will be reviewed with all staff at the September staff meeting.

This regulation and the entire list of resident rights will be gone over at the August 26, 2026 Resident Council meeting with the residents. The Administrator did this on August 26, 2026.

This list and all residents' rights will be reviewed with all staff during our September staff meetings. We will continue to review one item from the resident rights list at each staff meeting.

Additionally, added into this years training calendar is "Knowing the Rights of Residents", Relias Course REL-PAC-0-KRR for one hour. This has been added to all Heritage PCA's, med techs and nursing staff. Staff must have this completed no later than December 31, 2026.

Designate responsibility and specific target dates for correction--

The Administrator will ensure that all staff have been retrained on residents' rights and provide a signature (sign-in list) of that education upon completion.

Evidence of compliance—ongoing, to be submitted after all staff have signed/been educated. Course description of Relias attached.

Licensee's Proposed Overall Completion Date: 08/27/2026

Implemented [REDACTED] - 10/08/2026)

185a - Implement Storage Procedures

3. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures (*continued*)**Description of Violation**

Resident #2's glucometer indicated multiple blood glucose readings which were not recorded on the resident's July 2026 medication administration record (MAR) to include:

**7/1/26 - blood glucose of 201 at 07:13 and blood glucose of 212 at 07:15*

**7/2/26 - blood glucose of 92 at 02:45*

Plan of Correction

Accept () - 09/01/2026)

Immediate Action— *The team members who took the readings but did not record them were re-educated verbally upon identification of the violation.*

Changing practice, teaching, and ongoing monitoring—(position of who will be monitoring)

This regulation will be reviewed with all staff at the September staff meeting.

Midnights staff will check the glucometer vs. eMAR daily for 30 days to ensure compliance, then weekly for 4 weeks, then every other week for 2 months, then once a month for 2 months. This makes it a 6-month plan. Any irregularity will result in a complete audit from the Resident Care Coordinator and a restart of the audit (daily, weekly, monthly, etc.)

Designate responsibility and specific target dates for correction—

Midnight med tech, Resident Care Coordinator

Starting 8/26/2026 through 2/28/2027.

Evidence of compliance—Signatures of re-education of all staff after attending the September staff meeting.

Licensee's Proposed Overall Completion Date: 09/10/2026

Implemented () - 10/08/2026)

202 - Prohibitions

4. Requirements

2600.

202. The following procedures are prohibited:

6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On 6/26/26 at approximately 12:30 p.m., direct care staff A and direct care staff person B were providing toileting assistance to resident #1 when the resident became verbally agitated and physically aggressive. Direct care staff A did not follow the resident's support plan to provide space. Rather, direct care staff A utilized physical prompting on the resident's hips and shoulders in progressively increasing force to move the resident onto the toilet. Once on the toilet, direct care staff A held the resident's wrists to prevent the resident from striking the staff, causing the resident to state "Ow! You're hurting me!"

202 - Prohibitions (continued)

Plan of Correction

Accept () - 09/01/2026)

Immediate Action— The team member identified as treating a resident inappropriately was terminated. We will not tolerate any mistreatment of our residents.

Changing practice, teaching, and ongoing monitoring—(position of who will be monitoring)

This regulation will be reviewed with all staff at the September staff meeting.

Designate responsibility and specific target dates for correction--

The Administrator will ensure that all staff have been educated on this regulation and violation. And proper techniques, including prompting, escorting, and guiding.

Evidence of compliance—Staff signatures will be obtained as they are educated on this regulation and violation.

Licensee's Proposed Overall Completion Date: 09/30/2026

Implemented () - 10/08/2026)

233c - Key-Locking Devices

5. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 7/8/26 at 12:08 p.m. the codes posted near both exit doors leading to the Serenity Lane Courtyard in the Secured Dementia Care Unit (SDCU) were incorrect and a different code had to be entered to release the locking system.

Plan of Correction

Accept () - 09/01/2026)

Immediate Action—Immediately, all butterfly codes (all 8) were audited, and two were replaced on that same day, July 8, 2026. The ones replaced were near both exit doors leading to the Serenity Circle courtyard in the JSC neighborhood. (The VR indicates Serenity Lane Courtyard, but it was in Serenity Circle. Our Serenity Lane neighborhood does not have an outside courtyard area)

Changing practice, teaching, and ongoing monitoring—(position of who will be monitoring)

This regulation will be reviewed with all staff at the September staff meeting.

Our midnight PCA will check all 8 of these coded butterflies weekly. () has been given instructions and replacement butterflies if one is needed. The Jones Serenity Circle neighborhood manager will audit the audit sheet and ensure compliance with this regulation.

Designate responsibility and specific target dates for correction—

Weekly audit added to pca on midnight shift to be completed monthly.
Neighborhood manager on JSC to audit.

Evidence of compliance—

233c - Key-Locking Devices (continued)

I have also attached the in-progress audit sheet and a blank copy of the same audit sheet, as well as the emailed instructions and initial education on this audit to be provided.

Licensee's Proposed Overall Completion Date: 08/27/2026

Implemented () - 10/08/2026)

233d - Electronic/Magnetic System**6. Requirements**

2600.

233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

On 7/8/26 at 12:05 p.m., the locking device on the emergency exit gate located in the Serenity Lane Courtyard of the SDCU and opening to an outside sidewalk, disengaged simultaneously when the code was entered at the inside door that exited to the Serenity Lane Courtyard, approximately 25 yards from the gate.

Plan of Correction

Accept () - 09/01/2026)

Immediate Action— *The programmer from Professional Electronics was contacted and came out that same day (July 7/8/2026) and fixed a broken relay and tested the entire system, including all door and gate locks. Everything was working appropriately before departure.*

Changing practice, teaching, and ongoing monitoring—(position of who will be monitoring)

This regulation will be reviewed with all staff at the September staff meeting.

The maintenance supervisor will check this locking system monthly, on the second Tuesday of each month, and contact Professional Electronics if there is a need. If there is a need to call Professional Electronics, then the Administrator must be contacted immediately.

Designate responsibility and specific target dates for correction--

Maintenance Supervisor, 7/8/2026 and ongoing monitoring.

Evidence of compliance—*a copy of the invoice for the service is in Sans Write.*

Licensee's Proposed Overall Completion Date: 08/27/2026

Implemented () - 10/08/2026)