

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

September 14, 2026

[REDACTED]
ECUMENICAL ENTERPRISES, INC.
[REDACTED]
[REDACTED]

RE: THE MEADOWS MANOR
200 LAKE STREET
DALLAS, PA, 18612
LICENSE/COC#: 24365

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE MEADOWS MANOR

License #: 24365

License Expiration: 09/20/2026

Address: 200 LAKE STREET, DALLAS, PA 18612

County: LUZERNE

Region: NORTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: ECUMENICAL ENTERPRISES, INC.

Address:

Phone:

Email:

Certificate(s) of Occupancy

Type: C-2 LP

Date: 12/04/1996

Issued By: DLI

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 51

Waking Staff: 38

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Incident

Exit Conference Date: 07/17/2026

Inspection Dates and Department Representative

07/09/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 66

Residents Served: 46

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 46

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 5

Have Physical Disability: 0

Inspections / Reviews

07/09/2026 Partial

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 08/20/2026

08/17/2026 - POC Submission

Submitted By:

Date Submitted: 08/24/2026

Reviewer:

Follow-Up Type: POC Submission

Follow-Up Date: 08/21/2026

Inspections / Reviews (*continued*)

08/20/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/24/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/25/2026

09/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/24/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED] at approximately 11:15a.m., staff person A entered the room of resident [REDACTED] to remind the resident about lunch. Resident [REDACTED] appeared upset and was resistant coming to lunch. Resident [REDACTED] then revealed that resident # [REDACTED] groped their [REDACTED] this morning after breakfast in the doorway of the resident [REDACTED]'s room. Resident [REDACTED] asked resident [REDACTED] to stop, which they did. However, resident [REDACTED] reported that resident [REDACTED] followed them into their bedroom and groped resident [REDACTED] again. Resident [REDACTED] then exited the room.

Plan of Correction

Accept [REDACTED] 08/20/2026)

1. What is the reason for the regulation?

Regulation 2600.42(b) intent is to ensure residents residing within community settings and care homes are not neglected, intimidated, physically or verbally abused, mistreated, subject to corporal punishment or disciplined.

2. What is the root cause of the violation?

The accused resident had difficulty understanding personal boundaries or consent; potential misinterpretation of another resident's behavior or social cues; or was seeking affection, attention or physical contact.

3. How can we fix the immediate problem?

The accused resident was initially removed from the facility by a companion for a period of time. Upon their return, they in addition to the suspected victim were placed on frequent checks by staff; responsible parties of all involved were made aware in addition to all staff members. Resident #2 and responsible parties were clearly communicated with regarding the incident, response and expectations of behavior conducive to congregate living.

4. Once corrected, how can we make sure the problem does not happen again?

Effective 8/18/2026; the facility has issued a 30-days' notice to Resident [REDACTED] & their responsible parties. (Attachment #1) The letter was hand delivered and discussed with Resident [REDACTED] by PCHA. Additionally, an email with the letter attached was sent by PCHA to Responsible parties. Lastly, a certified copy was mailed to Responsible Party #1. On 8/19/26 a conference call was held with Responsible Party #1, PCHA and Administrative Assistant. Responsible Party #1 notified facility that they had received the communication and acknowledged the decision of the facility. PCHA notified that Resident #2 will be discharged to a home living situation with their sister on Monday 8/24/26 with family support. Responsible Party #1 has contacted a neurologist to schedule a consultation with Resident [REDACTED] #2 to provide further medical oversight.

5. Who is responsible to fix the problem?

On 8/18/2026 all staff members of The Meadows Manor were in-serviced again regarding the alleged incident and the facility decision to issue the 30-days' notice. (Attachment #2) It will be all staff members responsibility to continue monitoring Resident #2 on a daily basis and frequently until their discharge on 8/24/26. Nursing

42b Abuse (continued)

department will be responsible to continue documenting Q/15 minute checks on eMar and ancillary paper documentation. PCHA & LPN Supervisor will be responsible to review documentation of nursing department on a daily basis until discharge to ensure continued compliance.

6. By what dates can each step in the plan be completed.

- a. AAA verbal report filed 6/27/26
- b. DHS Initial IR Report filed 6/27/26
- c. Investigation initiated & routine checks immediately in place for both residents 6/27/26
- d. RP's of both residents notified 6/27/26
- e. AAA written Act 70 report sent 6/29/26
- f. Formal letter drafted and sent to Resident #2 & Responsible party 6/29/26
- g. Updated IR Report sent to DHS 7/7/26
- h. Police report filed 8/5/26
- i. PCHA meeting with resident council to review and discuss resident rights, abuse and abuse reporting 8/13/26
- j. 30 day notice given 8/18/26
- k. Nursing documentation continues (ongoing since 6/27/26)
- l. Second Inservice provided to all staff regarding close monitoring of Resident #2 and facility decision to issue a 30 days' notice 8/18/26
- m. PCHA & Nursing supervisor oversight of routine check documentation initiated 8/18/26 (will continue until discharge)
- n. Notification of discharge on 8/24/26 given to facility by responsible party 8/19/26
- o. Anticipated discharge of resident 8/24/26

7. How will we monitor to be sure the plan is followed?

It will be the responsibility of all department heads to oversee their teams and ensure continued monitoring from all staff. It is the responsibility of the PCHA & LPN Supervisors to sign off daily and review nursing documentation regarding routine checks in place. The PCHA will be responsible for continued communication with the responsible party and resident regarding the safety plan in place within the facility, planning for a coordinated discharge, and ensure the discharge occurs.

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

Implemented  - 09/14/2026)