

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

September 24, 2026

[REDACTED], NHA
HENDORN INC
1001 EAST SECOND STREET
[REDACTED]
COUDERSPORT, PA, 16915

RE: COLE MANOR
101 MAPLE STREET
COUDERSPORT, PA, 16915
LICENSE/COC#: 24263

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/13/2026 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: COLE MANOR

License #: 24263

License Expiration: 08/09/2026

Address: 101 MAPLE STREET, COUDERSPORT, PA 16915

County: POTTER

Region: NORTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: HENDORN INC

Address: 1001 EAST SECOND STREET, [REDACTED] COUDERSPORT, PA, 16915

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 08/20/1990

Issued By: DLI

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 21

Waking Staff: 16

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Incident

Exit Conference Date: 07/13/2026

Inspection Dates and Department Representative

07/13/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 30

Residents Served: 21

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 21

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 0

Have Physical Disability: 0

Inspections / Reviews

07/13/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/20/2026

09/03/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/20/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/10/2026

Inspections / Reviews (*continued*)

09/17/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/20/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/21/2026

09/24/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/20/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c Written Incident Report**1. Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #4 has an order for Insulin Aspart U-100 subcutaneous – 7 units before meals, adjust with sliding scale: add 2 units if blood sugar is between 151 and 200, add 4 units if blood sugar is between 201 and 250. On 7/4/26 at 5:00 p.m. the residents blood glucose measured 297, the resident was given 9 units. There is no additional order if the resident's blood glucose measures above 250. On 7/11/26 at 5:00 p.m. the resident's blood glucose measured 220, the resident was given 7 units of insulin but should have received 11 units. On 7/13/26 at 5:00 p.m. the resident's blood glucose measured 251 and 13 units of insulin was administered, the sliding scale does not have a dosage listed when the blood glucose exceeds 250. The medication errors have not been reported to the Department.

Plan of Correction

Accept () - 09/17/2026)

The incident was reported to licensing. Please see attached verification of report as well an internal audit relative to Resident #4's blood sugar monitoring and current order. The administrator completed an audit of reported incidents on 8/8/26 to obtain the attached information. Audits will continue to occur by the administrator and lead medication technician to sustain compliance and compare any issues that need addressed. Cole Manor will continue compliance with all staff having annual diabetic training and compliance with med tech program requirements. Cole Manor will continue to complete applicable documentation and file with QMP and in resident file. 4-week audit completed as of 8/31/26 by administrator and medication tech staff to ensure compliance and accuracy and will continue on a monthly basis.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)

42b Abuse**2. 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] Resident #2 reported to Staff Person A "That [REDACTED] that was in my room last night," referring to Resident #1, the resident had touched Resident #2's [REDACTED], [REDACTED], but it didn't feel right.' Per nursing notes dated [REDACTED] Resident #1 was found in Resident #2's room, sitting on the bed, but it was noticed that Resident #2 did not have the same pants on as earlier in the day, [REDACTED]. When staff asked Resident #2 what the residents were doing the resident responded, " I was helping with the pants". Resident #2 was interviewed on 7/13/26 regarding the incident and had no recollection of the incident the resident reported to staff on [REDACTED] Resident #1's Medical Evaluation dated [REDACTED] indicates the resident requires assistance with higher level of decision making. Resident #1s no longer lives in the home and was unable to be interviewed.

42b Abuse (continued)

Plan of Correction

Accept () - 09/17/2026)

Resident #1 was already placed on a 30 day notice at the time of the incident. Resident #1 had not shown behaviors towards other residents, but the facility had consulted with the residents PCP, neurologist and gotten a behavioral health referral prior to this incident occurring. Both residents involved have cognitive impairment and the incident was immediately reported to licensing and older adult protective services. Since the incident, Resident #1 has been discharged () and resident #2 remains at the facility. The facility has also held older adult protective services training for staff to re educate on reporting requirements and safety (see attachment). The administrator ensures all staff complete abuse training on an annual basis which occurred and was followed given staff reported the incident as soon as it occurred and separated the residents. Administrator will continue compliance with annual training requirements relative to abuse, neglect, exploitation (OAPSA) and retrained staff as of 7/16/26 due to incident. Administrator is responsible for continued monitoring of compliance and updated trainings when needed outside of annual requirement. Staff are responsible for attending and completing mandatory trainings.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)

132g - Fire Drills Days/Times

4. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home frequently schedules 1 staff on shift from 11:00 p.m. to 6:30 a.m. On 11/14/25 at 10:12 p.m. the fire drill had 2 staff participating. On 5/22/25 at 5:51 a.m. the fire drill had 3 staff participating. The home routinely holds sleeping hours fire drills with more staff then they schedule during sleeping hours.

Plan of Correction

Accept () - 09/17/2026)

Third shift staff are scheduled until 6:30AM but first shift staff begin at 6AM. On the day of the third shift fire drill the first shift staff had clocked in early for first shift, it was not intended to occur because a fire drill was occurring which was not prescheduled. To correct this, a third shift fire drill was conducted successfully since the inspection (see attached) and another will occur within six months to remain compliant and when only one third shift person is on. Administrator will continue to hold monthly fire drills and ensure compliance with time and attendance of drills including a non awake fire drill every 6 months from last completed non awake drill.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)

162c - Menus Posted

6. Requirements

2600.

162c Menus Posted (continued)

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 7/13/26 the menus were posted through 7/19/26.

Plan of Correction

Accept () - 09/17/2026)

Menus were posted for current week. In order to correct this, two weeks' worth of menus have since been posted (see attachment) and will continue to be posted at least ten days out. Administrator will complete weekly menus and post at least 8 days out to ensure compliance.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)

183e - Storing Medications**7. 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

Resident #4 utilizes Degludec (100 unit) quick pen. There was no date on the pen when it was opened. The manufacturer label indicates it should be discarded after being open for 56 days.

Plan of Correction

Accept () - 09/17/2026)

Audits have been put in place to ensure compliance with quick pen storage and education has been provided to staff (please see attached). 4 week audit completed as of 8/31/26 by administrator and medication tech staff to ensure compliance and accuracy and will continue on a monthly basis.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)

185a - Implement Storage Procedures**8. 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.

Description of Violation

On 7/4/26 at 7:43 a.m. Resident # 5's glucometer indicated a blood glucose reading of 94. 97 was incorrectly recorded on the Medication Administration Record.

Resident #4 utilizes a Dexcom, there is no log on the device to compare to the Medication Administration Record.

Plan of Correction

Accept () - 09/17/2026)

Audits of medications have been put in place to ensure compliance with medication administration expectations and resident has created a log in for dexacom (please see attached). 4 week audit completed as of 8/31/26 by

185a - Implement Storage Procedures (continued)

administrator and medication tech staff to ensure compliance and accuracy and will continue on a monthly basis.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026

187d - Follow Prescriber's Orders**9. Requirements**

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #4 has an order for Insulin Aspart U-100 subcutaneous – 7 units before meals, adjust with sliding scale: add 2 units if blood sugar is between 151 and 200, add 4 units if blood sugar is between 201 and 250. On 7/4/26 at 5:00 the residents blood glucose measured 297, the resident was given 9 units. There is no additional order if the resident's blood glucose measures above 250. On 7/11/26 at 5:00 p.m. the resident's blood glucose measured 220, the resident was given 7 units of insulin but should have received 11 units. On 7/13/26 at 5:00 p.m. the resident's blood glucose measured 251 and 13 units of insulin was administered, the sliding scale does not have a dosage listed when the blood glucose exceeds 250.

Plan of Correction

Accept () - 09/17/2026

Audits of medications have been put in place to ensure compliance with medication administration expectations. 4-week audit completed as of 8/31/26 by administrator and medication tech staff to ensure compliance and accuracy and will continue on a monthly basis. Communication of any issues will be shared with medical provider when needed by administrator and medication staff.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026

188b - Medication Error Reporting**10. Requirements**

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #4 has an order for Insulin Aspart U-100 subcutaneous – 7 units before meals, adjust with sliding scale: add 2 units if blood sugar is between 151 and 200, add 4 units if blood sugar is between 201 and 250. On 7/4/26 at 5:00 p.m. the residents blood glucose measured 297, the resident was given 9 units. There is no additional order if the resident's blood glucose measures above 250. On 7/11/26 at 5:00 p.m. the resident's blood glucose measured 220, the resident was given 7 units of insulin but should have received 11 units. On 7/13/26 at 5:00 p.m. the resident's blood glucose measured 251 and 13 units of insulin was administered, the sliding scale does not have a dosage listed when the blood glucose exceeds 250. This has not been reported to the resident, the prescriber, or the responsible party.

Plan of Correction

Accept () - 09/17/2026

Updated order has been obtained and incident reported to department. Internal medication audits remain in place to ensure compliance. 4-week audit completed as of 8/31/26 by administrator and medication tech staff to ensure

188b - Medication Error Reporting (continued)

compliance and accuracy and will continue on a monthly basis. Communication of any issues will be shared with medical provider when needed by administrator and medication staff. Administrator to ensure compliance by medication staff on going basis. Information to be contained with QMP and in resident file.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)

225c - Additional Assessment**11. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's assessment dated [REDACTED] does not note the resident's increased fall risk or inappropriate behaviors towards [REDACTED] residents.

Resident #2's assessment dated [REDACTED] notes the resident is alert and oriented and does not have any problems with judgement. The resident's assessment has not been updated regarding their current care needs.

Repeated Violation: 9/11/25

Plan of Correction

Accept () - 09/17/2026)

Resident #2 assessment has been updated to reflect their current care needs. An audit of assessments has occurred to ensure compliance and up to date status (see attached). Administrator will continue regular weekly audits of assessments to ensure up to date information is present and accurate and seek staff, resident and family input as needed.

Licensee's Proposed Overall Completion Date: 09/06/2026

Implemented () - 09/24/2026)