

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

September 14, 2026

[REDACTED]
SUNNY CREST HOME INC
[REDACTED]

RE: SUNNY CREST HOME
2587 VALLEY VIEW ROAD
MORGANTOWN, PA, 19543
LICENSE/COC#: 32192

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/22/2026, 07/23/2026 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: *SUNNY CREST HOME*

License #: 32192

License Expiration: 11/20/2026

Address: 2587 VALLEY VIEW ROAD, MORGANTOWN, PA 19543

County: LANCASTER

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: *SUNNY CREST HOME INC*

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED];

Certificate(s) of Occupancy

Type: C-2 LP

Date: 08/05/2007

Issued By: Department of Labor & Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 55

Waking Staff: 41

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Interim

Exit Conference Date: 07/23/2026

Inspection Dates and Department Representative

07/22/2026 - On-Site: [REDACTED]

07/23/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 71

Residents Served: 50

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 25

Are 60 Years of Age or Older: 30

Diagnosed with Mental Illness: 26

Diagnosed with Intellectual Disability: 21

Have Mobility Need: 5

Have Physical Disability: 2

Inspections / Reviews

07/22/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/20/2026

Inspections / Reviews (*continued*)

08/24/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/18/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 08/31/2026

08/31/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/29/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/10/2026

09/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

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] Resident [REDACTED] hit #Resident [REDACTED] while they were standing in line for snacks. Resident [REDACTED] stated that [REDACTED] chest hurt and [REDACTED] was administered [REDACTED] for [REDACTED]

On [REDACTED], Resident [REDACTED] wheeled [REDACTED] chair over to Resident [REDACTED] and hit [REDACTED] when [REDACTED] walked by. Resident [REDACTED] told Admin to tell Resident [REDACTED] to stop.

On [REDACTED] Resident [REDACTED] hit Resident [REDACTED] on [REDACTED] right arm. Resident [REDACTED] confirmed that the resident hit [REDACTED] and that Resident [REDACTED] needs to stop.

On [REDACTED], Resident [REDACTED] slapped Resident [REDACTED] on the arm twice.

On [REDACTED] Resident [REDACTED] was kicking and hitting Resident [REDACTED] which made Resident [REDACTED] cry. No injuries were noted.

Plan of Correction

Directed [REDACTED] - 08/31/2026)

Direct care staff will remain close and attentive to recognize escalating behavior and intervene before aggression occurs and redirecting the residents. Resident support plans will be revised and updated with risk assessment and documented history. Weekly audits will be done by Admin staff starting 8/20/2026

(Directed)

- Residents [REDACTED] and [REDACTED] will be reassessed in the areas of behavior and supervision by 9/7/26.
- All other residents in the home with a history of aggression towards others will have their supervision reassessed by 9/7/26.
- Education will be provided to all staff on how to implement increased supervision including distance staff should be for those with supervision needs, as well as how to de-escalate behaviors and prevent physical abuse between residents.
- Beginning no later than 9/7/26, the administrator or designee will review internal documentation to include resident behaviors towards others at least once per week. Residents who continue to display aggression towards others will be reassessed and decision to be made by the home if the home can continue to meet the needs of the resident(s) safely.
- Documentation of updated assessments, education to staff and weekly audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/07/2026

Implemented [REDACTED] - 09/14/2026)

60a - Staff/Support Plan

2. Requirements

2600.

60a Staff/Support Plan (continued)

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [REDACTED] and [REDACTED], there were only 2 staff members scheduled and present in the personal care home from 10:00 PM 6:00 AM to serve 50 residents, including 5 residents with mobility needs (2 requiring a 2 person transfer with a Hoyer lift). Each transfer with a Hoyer lift requiring 2 staff members and takes approximately 5 minutes per resident. The home has a maximum evacuation time of 8 minutes 0 seconds. Based on the needs of the residents, 2 staff members are not sufficient to safely evacuate all residents in the event of an emergency.

Repeated Violation [REDACTED], et al., [REDACTED], et al.

Plan of Correction

Directed [REDACTED] - 08/31/2026)

Administrator conducting a review of current overnight staffing levels and resident care needs and make the adjustments to meet the needs of the residents. 8/19/2026 Admin staff will educate the designee staff on scheduling 3 staff member on the overnight to ensure proper coverage to meet the needs of the residents. Starting 8/19/2026 Administrator staff will do a audit weekly to ensure there 3 staff on the overnight shift to meet the needs of the residents

(Directed)

In addition to the above plan of correction:

- An overnight fire drill will be held between the hours of 2:00 AM and 4:00 AM no later than the morning of 9/2/26 with only 3 staff participating. If the home is unable to safely evacuate within the time specified by a fire safety expert, then the home will increase staffing during overnight shifts or reassess residents needs to determine if the home can continue to safely meet the needs of each resident.

Directed Completion Date: 09/02/2026

Implemented [REDACTED] - 09/14/2026)

132d - Evacuation**3. 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 had a maximum safe evacuation time of 8 minutes 0 seconds specified in writing within the past year by a fire safety expert. During a fire drill conducted on [REDACTED] at 10:55 AM, the home exceeded this evacuation time with a time of 9 minutes and 30 seconds.

132d - Evacuation (*continued*)**Plan of Correction****Accept** [REDACTED] - 08/24/2026)

8/17/2026 -Administrator reviewed the fire drill result with the staff to identify the the factors that contribute to the extended time. 8/19/2026- Staff will be re-educated on the importance of the facility emergency evacuation times and procedures , including assigned responsibilities prompt response to alarms and resident evacuation. 9/1/2026- The facility will conduct a fire drill to reinforce staff competency and efficient evacuation times

Licensee's Proposed Overall Completion Date: 09/01/2026

Implemented [REDACTED] - 09/14/2026)

132h - Designated Meeting Place

4. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During a fire drill conducted on [REDACTED] at 10:55 AM, not all residents evacuated to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction**Directed** [REDACTED] - 08/31/2026)

On 7/23/2026 Administrator reviewed the fire drill to determine whether additional staff support and prompting needed to get the residents to a safe area. 8/19/2026 Staff will be re-educated on the importance of fire emergency and evacuation procedures and getting the residents to a safe area. Starting 9/1/2026 Admin staff will monitor fire drills to identify any deficiencies and address them immediately .

(Directed)

In addition to the above plan of correction:

- All residents will receive education on the requirements for each resident to participate in fire drill evacuations. Education to be completed to all residents by 9/7/26 by the administrator or designee.
- Documentation of completed education to staff and residents will be kept by the home and available for review by the Department.

Directed Completion Date: 09/07/2026

Implemented [REDACTED] 09/14/2026)

184a - Resident's Meds Labeled

5. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident [REDACTED] had prescriber orders for Hydrofera blue foam dressing 4x4" apply topically to right knee wound and

184a Resident's Meds Labeled (continued)

change Monday, Wednesday and Friday for wound care. The pharmacy label on the resident's dressing indicated apply dressing to right thigh wound, secure with gauze or tape, change 3 times weekly and as needed.

Resident [REDACTED] had prescriber orders for Vashe wound therapy soak Right knee wound and surrounding areas 3 times weekly and soak Right knee wound and surrounding areas for 10 mins as needed. The pharmacy label on the resident's treatment bottle indicated clean wounds and surrounding area with vashe wound cleaner and soak for 10 mins.

Plan of Correction**Directed [REDACTED] - 08/31/2026)**

8/19/2026 All med aide will be re educated on the requirement to follow the prescribed label exactly as written. Starting 8/20/2026 Nursing staff will conduct a routine medication cart audit to verify that the medication are labeled properly and Med aides are following the dosage instructions. Any identified discrepancies will be corrected immediately and addressed through additional follow up and monitoring by Nursing staff

(Directed)

In addition to the above plan of correction:

- Resident [REDACTED] will receive corrected pharmacy labels by 9/7/26.
- Starting no later than 9/7/26, weekly audits of resident medication pharmacy labels will be compared against the physician's orders for a minimum of 3 months.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/07/2026

Implemented [REDACTED] - 09/14/2026)**185a - Implement Storage Procedures****6. 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

Resident [REDACTED] was prescribed [REDACTED] caplet take 2 tablets (1000MG) by mouth every 8 hrs. as needed for pain. On [REDACTED] at approximately 1:30 PM, this medication was not available in the home.

Plan of Correction**Directed [REDACTED] - 08/31/2026)**

The medication in question was not ordered in time for the resident PRN. 8/19/2026 Retraining the med aide staff on the importance of monitoring medication supplies and initiating refill request to prevent missed and delayed dose. starting 8/20/2026 Nursing staff will monitor medication supplies and routinely and promptly notify provider/pharmacy of medication requiring renewal or refill. 9/1/2026 Administrator will audit medication list to ensure availability and refill request

See Attached;

The Medication was in the building it was a oversight, it was in a card not a bottle.

(Directed)

185a - Implement Storage Procedures (continued)

In addition to the above plan of correction:

- *Resident's Acetaminophen became available in the home on during the evening of 7/23/26.*
- *Beginning no later than 9/7/26, the administrator or designee will complete weekly medication audits to ensure medications are available for administration, including PRN's.*
- *Documentation of staff education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/07/2026

Implemented () - 09/14/2026)

224a - Preadmission Screen Form**7. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident's preadmission screening form, dated does not include a determination that the needs of the resident can be met by the services provided by the home.

Repeated Violation – , et al

Plan of Correction

Directed () - 08/31/2026)

The preadmission screen form was corrected 8/17/2026 by the administrator, see attached. During the preadmission screen Administrator will review the forms after the Admin staff has completed it to prevent this from happening again.

(Directed)

In addition to the above plan of correction;

- *An initial audit on all current resident preadmission screens will be completed by the administrator or designee by 9/10/26. Documentation of the completed audit will include any screenings found to be non-compliant.*
- *Beginning no later than 9/7/26, the administrator or designee will review preadmission screenings within 24 hours of the resident's admission to the home to ensure the document is completed properly and thoroughly.*

Directed Completion Date: 09/10/2026

Implemented () - 09/14/2026)