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

October 13, 2026

[redacted]
HIGHLAND PARK SENIOR LIVING LLC
[redacted]

RE: HIGHLAND PARK SENIOR LIVING
874 SCHECHTER DRIVE
WILKES-BARRE TOWNSHI, PA, 18702
LICENSE/COC#: 22630

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/27/2026 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: *HIGHLAND PARK SENIOR LIVING* **License #**: *22630* **License Expiration**: *02/18/2027*

Address: *874 SCHECHTER DRIVE, WILKES BARRE TOWNSHI, PA 18702*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HIGHLAND PARK SENIOR LIVING LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/01/2018* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *102* **Waking Staff**: *77*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/27/2026*

Inspection Dates and Department Representative

08/27/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *160* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *24* **Residents Served**: *24*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *71*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *31*

Have Physical Disability: *1*

Inspections / Reviews

08/27/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/26/2026*

10/07/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/08/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/09/2026*

Inspections / Reviews *(continued)*

10/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/08/2026*

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

182c - Medication Administration

1. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

Resident [redacted] was prescribed [redacted] tablets to be administered daily at 8:00 a.m. and 8:00 p.m. On [redacted] at 8:00 a.m. staff person A administered the resident's morning medications however did not verify that the prescribed medication was included in the package containing multiple medications that was administered to the resident, which resulted in the resident not receiving the morning dose of the medication.

Plan of Correction ***Accept [redacted] 10/07/2026)***

Please see attached.
All staff authorized to administer medications were re-educated on medication administration procedures by [redacted] LPN, ED, Med Train the Trainer, on 9/21/26. Education included, but not limited to verification of the correct resident, medication dosage, route, prescribed time, MAR accuracy, MOT packaging contents against MAR, prevention of omission of medications from multi-medication packages and medication packaging against the current physician's orders and MAR. Staff were instructed that if a medication listed on the MAR is not present in the pharmacy package, the medication must stop the medication administration process for that medication, notify the supervisor/pharmacy/resident pcp/prescriber and family member as appropriate, because failure to administer a prescribed medication, administration at the wrong time, or any other medication discrepancy constitutes a medication error. Staff will document the error, pcp/prescriber response in the resident record, and documentation of follow-up action to prevent reoccurrence.
[redacted] Wellness Coordinator, MTT and [redacted] LPN, ED, Med Train the Trainer completed the 1st medication pass observation with each staff person authorized to pass medications on 9/21/26 and 9/22/26.
[redacted] Wellness Coordinator, MTT or designee [redacted] LPN, ED, MTT in Jessicas absence will continue weekly observations on the staff person authorized to pass medications for four consecutive weeks ending 10/30/26, following the initial four-week monitoring, monthly observations will be completed for two additional months, ending 12/30/26.
[redacted] LPN, DOW and [redacted] Wellness Coordinator will audit monthly MOT packs against the MARs on admission monthly from pharmacy to ensure medications are packaged correctly. MAR/pharmacy packaging audits will be maintained and reviewed monthly by [redacted] LPN, ED to ensure compliance.

Licensee's Proposed Overall Completion Date: *09/24/2026*

Implemented [redacted] - 10/13/2026)

185a - Implement Storage Procedures

2. 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

The home's medication policy indicates that medications destroyed in the home will be documented. Staff person A advised that on [redacted] a bottle of [redacted] tablets belonging to resident [redacted] was destroyed however no record of the destruction of the medication was kept.

185a Implement Storage Procedures *(continued)*

Plan of Correction ***Accept [redacted] 10/07/2026)***

Please see attached.

[redacted] LPN, ED, Med Train the Trainer re educated each staff person authorized to pass medications on 9/21/26 regarding the homes medication storage, accountability and disposal procedures. Staff were instructed that when medication is destroyed in the home, the required documentation must be completed at the time of destruction with a second staff member who is approved to pass medications and with [redacted] Wellness Coordinator, Med Train the Trainer or [redacted] LPN, DOW approval first. The destruction/disposal record will include the resident name, medication, strength, quantity, date, reason for destruction and signatures/identification of the two authorized staff members completing or witnessing the destruction.

[redacted] LPN, DOW will ensure that the medication destruction/disposal log/form is readily available to staff.

[redacted] LPN, ED, MTT will review the destruction/disposal documentation for four consecutive weeks to verify that all medications destroyed in the home are properly documented ending on 10/30/26 then monthly for two additional months ending on 12/30/26. If there is any missing or incomplete documentation on the disposal of medication forms found during audits, it will be addressed immediately, and additional retraining will be provided.

[redacted] LPN, ED will review audits weekly to ensure the destruction/disposal log form to ensure they are documented properly.

Licensee's Proposed Overall Completion Date: *09/24/2026*

Implemented ([redacted] - 10/13/2026)

187b - Date/Time of Medication Admin.

3. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident is [redacted] is prescribed [redacted] tablets to be administered twice daily at 8:00 a.m. and 8:00 p.m. Resident [redacted] August medication administration record includes the initials of the staff who administered the medication on [redacted] at 8:00 a.m., [redacted] at 8:00 p.m. and [redacted] at 8:00 p.m. however interviews with staff confirmed the medication was not administered.

Plan of Correction ***Accept [redacted] - 10/07/2026)***

Please see attached.

[redacted] LPN, ED, Med train the Trainer re educated each staff person authorized to pass medications on 9/21/26 regarding the requirements for accurate medication administration documentation.
Staff were instructed that the date/time of administration and the staff person's initals must be recorded at the time the medication is administered. Staff were instructed not to document a medication as administered if the medication was not actually administered.

[redacted] MTT or [redacted] LPN, ED, MTT ([redacted] designee) will conduct weekly medication pass observations with staff authorized to pass medications. Observations will be conducted weekly for four weeks ending 10/30/26 then monthly for two months ending 12/30/26 to verify that medications are documented as administered and that the date and time recorded accurately correspond with the administration, the medication was actually administered, staff member who administered medication is identified by the appropriate initials, and omissions, refusals or other medication discrepancies are documented appropriately.

[redacted] LPN, ED, MTT will review observations weekly then monthly to ensure compliance.

Licensee's Proposed Overall Completion Date: *09/24/2026*

187b - Date/Time of Medication Admin. *(continued)*

Implemented [redacted] ***- 10/13/2026)***

187d - Follow Prescriber's Orders

4. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] *is prescribed* [redacted] *tablets to be administered at 8:00 a.m. and 8:00 p.m. However, as per interviews with staff, the resident* [redacted] *was not administered the medication on* [redacted] *at 8:00 p.m.,* [redacted] *at 8:00 p.m. and* [redacted] *at 8:00 a.m.*

Repeated violation [redacted]

Plan of Correction ***Accept*** [redacted] ***- 10/07/2026)***

Please see attached.

[redacted] *LPN, ED, MTT re-educated all staff authorized to administer medications on 9/21/26 regarding the requirement to follow current prescriber's orders and complete medication administration as ordered. Staff were instructed that medications must be administered according to the current physician order, including the prescribed medication, dosage, route, frequency and administration time. Staff were instructed that if a medication is not available in the medication packaging/MOT pack or cart, the staff person should not document the medication as administered. The staff person must immediately notify* [redacted] *LPN, DOW or* [redacted] *Wellness Coordinator, MTT and follow the homes medication error procedure. Any discrepancy identified between the physician order, MAR and medication packaging will immediately be investigated and corrected. Staff were re-educated that failure to administer a prescribed medication at the wrong time, wrong dose, administered to the wrong resident or administered by the wrong route is a medication error. Medication errors would be reported immediately and documented with the pcp/ prescribers response and follow up action to be documented in the residents' record. The home will document follow up action taken to prevent future medication errors and will monitor for patterns of medication errors.*

Staff authorized to pass medications were re-educated on medication administration and completed a competency based test which incorporated trainings.

[redacted] *Wellness Coordinator, MTT will review MARs monthly with all new and changed medication orders against the resident's current medication profile/MAR to ensure discontinued medications are removed, dosage or frequency changes are accurately reflected, and newly prescribed medications are added correctly. For all new admissions and medication changes,* [redacted] *Wellness Coordinator, MTT will compare the physician order, MAR and pharmacy medication packaging/MOT pack for the medication name, strength, dosage, route, frequency and administration times and will be corrected prior to administration if any discrepancy is identified during that process.*

[redacted] *Wellness Coordinator or* [redacted] *LPN, ED, MTT designee in* [redacted] *absence will continue weekly observations on the staff person authorized to pass medications for four consecutive weeks ending 10/30/26, following the initial four-week monitoring, monthly observations will be completed for two additional months, ending 12/30/26.*

[redacted] *LPN, ED, MTT or* [redacted] *Wellness Coordinator, MTT will review observations weekly, then monthly to ensure compliance.*

Licensee's Proposed Overall Completion Date: *09/24/2026*

187d - Follow Prescriber's Orders *(continued)*

Implemented [redacted] - 10/13/2026)