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

September 19, 2025

[redacted], ADMINISTRATOR
BARNES AID OPCO LLC
[redacted]

RE: BARNES PLACE
2021 JAMES STREET
LATROBE, PA, 15650
LICENSE/COC#: 44488

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/29/2025 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: *BARNES PLACE* **License #:** *44488* **License Expiration:** *01/11/2026*

Address: *2021 JAMES STREET, LATROBE, PA 15650*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *BARNES AID OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/26/1997* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *82* **Waking Staff:** *62*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *04/29/2025*

Inspection Dates and Department Representative

04/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *68* **Residents Served:** *62*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *62*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *20* **Have Physical Disability:** *0*

Inspections / Reviews

04/29/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/06/2025*

06/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/31/2025*

Inspections / Reviews *(continued)*

09/19/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/01/2025*

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

26a - Quality Management Plan

1. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's Quality Management Plan does not include the periodic review of complaint procedures, licensing violations and plan of corrections.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

- *On 04/30/2025 The Homes Quality Management Plan was updated by the Executive Director to include the periodic review of complaint procedures, licensing violations and plans of correction. (Exhibit **A**)*
- *The Executive Director was re-educated on 04/30/2025 by the Regional Director of Operations on regulation 2600.26a. Documentation of the training will be maintained by the community. (Exhibit **B**)*
- *The Director of Health and Wellness or Designee will audit the QA meeting Minutes Monthly for 3 months to ensure that a review of the complaint procedures, licensing violations and plans of correction were included. The findings of this audit will be discussed with the QA committee monthly. The QA Committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/19/2025)

26b - Quality Management Plan Content

2. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
3. Staff person training.

Description of Violation

The home's quality management review, dated 7/31/24, did not address staff person training.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

- *On 04/30/2025 The homes monthly QI Committee Meeting Agenda and Minutes were updated by the Executive Director to include the periodic review of staff person training. (Exhibit **C**)*
- *The Executive Director was re-educated on 04/30/2025 by the Regional Director of Operations on regulation 2600.26b. Documentation of the training will be maintained by the community. (Exhibit **D**)*
- *The Director of Health and Wellness or Designee will audit the QA meeting Minutes Monthly for 3 months to ensure that a review of the staff person training was included. The findings of this audit will be discussed with the QA committee monthly. The QA Committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/19/2025)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

65f - Training Topics *(continued)*

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct Care Staff Person A did not receive annual training in any of the required training topics during training year 2024.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

- *Staff Person A received training on the topics outlined in regulation 2600.65f on 05/01/2025 by the Director of Facilities Operations, Business Office Manager and Executive Director. Documentation of the education will be maintained at the community (Exhibit **E**)*
- *The Business Office Manager was educated on regulation 2600.65f by the Executive Director on 05/01/2025. Documentation of the education will be maintained at the community (Exhibit **F**)*
- *Starting on 05/01/2025 the Business Office Manager or designee will audit 3 staff person training logs weekly x 4 weeks, then 2 staff persons training logs weekly x 4 weeks, then 1 staff person's training log weekly x 4 weeks to ensure continued compliance with regulation 2600.65f. The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff Person A did not receive any of the required training during training year 1/1/2024 to 12/31/2024.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

65g - Annual Training Content (continued)

- *Staff Person A received training on the topics outlined in regulation 2600.65fgon 05/01/2025 by the Director of Facilities Operations, Business Office Manager and Executive Director. Documentation of the education will be maintained at the community (Exhibit **E**)*
- *The Business Office Manager was educated on regulation 2600.65g by the Executive Director on 05/01/2025. Documentation of the education will be maintained at the community (Exhibit **H**)*
- *Starting on 05/01/2025 the Business Office Manager or designee will audit 3 staff person training logs weekly x 4 weeks, then 2 staff persons training logs weekly x 4 weeks, then 1 staff person's training log weekly x 4 weeks to ensure continued compliance with regulation 2600.65g. The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

81b - Resident Personal Equipment

5. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1 had an enabler bar attached to [redacted] bed with an uncovered opening that measured approximately 6 inches by 10 inches, posing an entrapment hazard.

Repeated Violation - 3/06/24

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

*• On 04/29/2025, the bed enabler for resident #1 was removed by the Executive Director and Director of Health and Wellness as resident #1 does not use the enabler any longer, they sleep in a recliner. (Exhibit **I**).*
• On 04/30/2025, an audit of resident rooms was completed by the Executive Director and no further violations of 2600.81b were identified.
*• Current staff were re-educated by the Executive Director on regulation 2600.81b on 05/28/2025. (Exhibit **J**) Documentation of the education will be retained within the community.*
*• Starting 05/01/2025, The Executive Director or designee will audit 5 resident's rooms/equipment weekly x 4 weeks, then 3 resident's rooms/equipment weekly x 4 weeks, then 1 resident's room/equipment weekly for 4 weeks to ensure continued compliance with regulation 2600.81b. (Exhibit **I**). The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

103f - Refrigerator/Freezer Temps

6. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/29/25 at 10:40 am, the temperature in the freezer in the kitchen was 15 degrees Fahrenheit and at 3:00 pm. it was 18 degrees Fahrenheit.

On 4/29/25 at 10:45 am, the temperature in the double freezer in the kitchen was 15 degrees Fahrenheit and at 3:00 pm, it was 5 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

- *The freezer in the kitchen was cycling in defrost mode each time that the temperature was checked. Temp returned to -5 degrees within 10 minutes of documented times. Culler refrigeration out on 04/30/2025 and confirmed that freezer was operating normally.*
- *On 04/29/2025, frozen food removed from double door freezer in kitchen and placed in the other double door freezer by the Head Chef.*
- *On 04/30/2025 Culler Refrigeration out to service the double freezer in the kitchen. Found filter drier restricted and part replaced. Freezer currently functioning normally. (Exhibit **K**)*
- *On 05/28/2025 the Head Chef and Cook were re-educated on regulation 2600.103f. Documentation of the education will be maintained within the community. (Exhibit **L**)*
- *Starting on 05/01/2025, the Director of Facilities Maintenance or designee will audit the Freezer Temps 3 x a week for 4 weeks, then 2x week for 4 weeks then weekly for 4 weeks to ensure continued compliance with regulation 2600.103f. The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

103g - Storing Food

7. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The following food items in the kitchen pantry were opened and unsealed:

103g - Storing Food (continued)

** Box of instant rice (2lbs 10oz)*
** Box Perfect Preboiled Rice (25lbs)*
** Box of thin spaghetti (16oz)*
** Bag of frosted flakes (approx. 6 cups)*
** Bag of rice crispies (approx. 6 cups)*

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

• On 04/29/20205 the opened box of instant rice, perfect preboiled rice, thin spaghetti, bag of frosted flakes and bag of rice Krispies were discarded by the Head Chef.
*• On 05/28/2025 the Head Chef and Cook were re-educated on regulation 2600.103g. Documentation of the education will be maintained within the community. (Exhibit **M**)*
• Starting on 05/01/2025, the Executive Director or designee will audit the kitchen pantry 3 x a week for 4 weeks, then 2x week for 4 weeks then weekly for 4 weeks to ensure continued compliance with regulation 2600.103g. The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 4/29/25, there was an approximate golf ball-sized accumulation of lint in the lint trap of Dryer #3. There were no clothes in the dryer at the time.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

- *On 04/29/2025 the lint accumulation in dryer #3 was discarded by the Executive Director*
- *On 04/29/2025 the lint traps of the dryers were checked by the Executive Director, and no further lint accumulations were found.*
- *On 05/29/2025 Current staff were re-educated on regulation 2600.105g by the Executive Director. Documentation of the education will be maintained within the community. (Exhibit **N**)*
- *Starting on 05/01/2025, the Director of Facilities Operations or designee will audit the lint traps of the dryers 3 x a week for 4 weeks, then 2x week for 4 weeks then weekly for 4 weeks to ensure continued compliance with regulation 2600.105g. The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.*

105g - Lint Removal and Duct Cleaning (continued)

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

185a - Implement Storage Procedures

9. 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 4/29/25, Resident #1 was ordered Lorazepam 0.5mg, take 1 tab by mouth every 6 hours as needed; however, this medication was not available in the home.

On 4/29/25, Resident #2 was ordered Lorazepam Con 2mg/ml, give 0.5ml sublingually every 4 hours as needed; however, this medication was not available in the home.

On 4/29/25, Resident #2 was ordered Tramadol 50mg, take 1 tab by mouth every 6 hours as needed and Biotene Mouthwash, swish and spit 4 times a day as needed; however, these medications were not available in the home.

Repeated violation - 3/06/24

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

*• On 04/29/2025, the Lorazepam Con 2mg/ml was delivered from the pharmacy for Resident #2. (Exhibit **O**).*
*• On 04/30/2025 orders were received from the MD to Discontinue the Tramadol and Biotene for Resident #3. (Exhibit **P**)*
*• On 04/30/2025, orders were received from the MD to Discontinue the Lorazepam for Resident #3. (Exhibit **Q**)*
• On 05/01/2025, an audit of current resident's Medications was completed by the Executive Director and Director of Health and Wellness and no further violations of 2600.185a were identified.
*• Current Med Techs were re-educated by the Director of Health and Wellness on regulation 2600.185a on 05/28/2025. (Exhibit **R**) Documentation of the education will be retained within the community.*
• Starting 05/11/2025, The Health Care Coordinator or designee will audit 5 resident's medications weekly x 12 weeks, to ensure continued compliance with regulation 2600.185a. (Exhibit). The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented ([redacted] - 09/19/2025)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident #2 was prescribed Humalog Kwik Insulin pen, inject per sliding scale before meals and at bedtime; however, on the following dates/times the resident was not administered the correct amount of insulin:
** 4/23/25 at 4 pm, blood glucose measured 177, the resident was administered 2 units; however, should have received 1 unit*
** 4/20/25 at 4 pm, blood glucose measured 171, the resident was administered 2 units; however, should have received 1 unit*
** 4/19/25 at 8:30 am, blood glucose measured 156, the resident was administered 2 units; however, should have received 1 unit*
** 4/17/25 at 4 pm, blood glucose measured 159, the resident was administered 3 units; however, should have received 1 unit*
** 4/05/25 at 4 pm, blood glucose measured 163, the resident was administered 3 units; however, should have received 1 unit*

Sliding Scale:
** 120-150 =0 units*
** 151-180 =1*
** 181-200 = 2 units*
** 201-250 = 3 units*
** 251-300 = 4 units*
** 301-350 = 6 units*
** 351-400 = 8 units*
** Greater than 400 - Call MD*

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

- *Resident #2's Physician and POA were notified on 04/30/2025 of the incorrect amount of insulin being administered on 04/23/2025, 04/20/2025, 04/19/2025, 04/17/2025, and 04/05/2025. (Exhibit **S**).*
- *Reportable Incident reporting form completed and submitted to the Bureau of Human Services on 04/30/2025. (Exhibit **T**).*
- *Resident # 2 evaluated by the Director of Health and Wellness on 04/30/2025, and no ill effects noted from the incorrect insulin dosage administrations.*
- *Current Med Techs were retrained on following the prescriber's orders in regard to Sliding Scale Insulin Administration by the Director of Health and Wellness and Health Care Coordinator on 05/05/2025. (Exhibit **U**).*
- *Starting on 05/01/2025, The Health Care Coordinator or Designee will audit the Blood sugar and insulin administration results for 3 residents 5x week x 4 weeks, then 2 residents 3 x week for 4 weeks, then 1 resident weekly for 4 weeks to ensure continued compliance with Regulation 2600.187d. (Exhibit) The findings of these audits will be discussed monthly at the QA meeting. The QA committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

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

Implemented (- 09/19/2025)

227d - Support Plan Medical/Dental

11. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2's medical evaluation, dated [redacted] indicates the resident needs to use a bedside commode. The resident's support plan, dated [redacted], does not document how this need will be met.

Plan of Correction ***Accept (- 06/10/2025)***

- *The Support Plan for Resident #4 was updated on 04/29/2025 to address the resident's need for a Bedside Commode. (Exhibit **V**)*
- *The Director of Health and Wellness was educated by the Executive Director on Regulation 2600.227d on 04/29/2025. (Exhibit **W**)*
- *The Director of Health and Wellness and or designee will audit 5 Support Plans weekly x 4 weeks, then 3 Support Plans Weekly x4 weeks, then 1 Support Plan weekly x 4 weeks to ensure continued compliance with regulation 2600.227d. The findings of these audits will be discussed monthly at the QA meeting. The QA Committee will determine if continued auditing is necessary based on 3 months of compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented (- 09/19/2025)