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

October 9, 2025

[redacted], CEO
CHRIST THE KING MANOR INC
[redacted]

RE: CHRIST THE KING MANOR
1100 WEST LONG AVENUE
DUBOIS, PA, 15801
LICENSE/COC#: 44864

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/01/2025, 07/02/2025, 07/10/2025, 07/25/2025, 07/28/2025, 08/04/2025 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: *CHRIST THE KING MANOR* **License #**: *44864* **License Expiration**: *06/20/2026*

Address: *1100 WEST LONG AVENUE, DUBOIS, PA 15801*

County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *CHRIST THE KING MANOR INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/15/1996* **Issued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *92* **Waking Staff**: *69*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *08/04/2025*

Inspection Dates and Department Representative

07/01/2025 - On-Site: [redacted]
07/02/2025 - On-Site: [redacted]
07/10/2025 - Off-Site: [redacted]
07/25/2025 - Off-Site: [redacted]
07/28/2025 - Off-Site: [redacted]
08/04/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *ALZ* **Capacity**: *20* **Residents Served**: *15*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *51*

Diagnosed with Mental Illness: *35* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *41* **Have Physical Disability**: *0*

Inspections / Reviews

07/01/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/12/2025*

09/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/22/2025*

09/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/03/2025*

10/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2025*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's initial assessment and support plan, dated [redacted] indicates the resident requires assistance in offering medications at prescribed times. To meet this need, staff will store medications and offer medications at prescribed times. Resident #1 is prescribed boric acid/cornstarch, apply daily and as needed [redacted]. On 7/1/25, resident #1's prescribed boric acid/cornstarch was stored in the resident's bedroom and the resident's July 2025 medication administration record contained no documentation of offering the medication to resident #1.

Plan of Correction ***Accept ([redacted] - 09/18/2025)***

It is our intent to offer the resident medications at prescribed times as indicated in the resident's assessment and support plan.
Boric acid/corn starch was immediately discontinued on 7/1/25 per physician's order and no medications will be stored in the resident's room.
All Medication Techs will review the support plans on admission and for significant change for how the resident needs assistance with ADL's and initial on the checklist that will be monitored on a weekly basis for 1 month then monthly for 3 months by our Wellness Director for compliance and reviewed by Quality Management Team.

Licensee's Proposed Overall Completion Date: *09/18/2025*

Implemented ([redacted] - 10/09/2025)

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 4/8/25, staff person A wrote out 3 checks to [redacted] from resident #1's checking account, and forged the resident's signature. Bank documentation confirms these 3 checks were deposited via mobile deposit to staff person A's bank account.

Plan of Correction ***Accept ([redacted] - 09/15/2025)***

2.2600.42b
It is our intent to that a resident is not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal or disciplined in anyway.
The staff person A who wrote out 3 checks to [redacted] from Resident #1's checking account and forged signature was terminated prior to learning of the occurrence. Staff person A was screened through a criminal background screen, interview process, reference check prior to employment and no indications were found.
Correction to ensure this will not occur was the termination of Staff A on [redacted]
Prevention of future occurrences included re-education of all staff members and residents. Residents are reminded

42b - Abuse (continued)

upon admission, during resident council meetings and periodically throughout the year to safeguard their valuables in the locked bedside drawer provided by the facility.
This will be monitored weekly for 1 month, then monthly for 3 months and at least additional 3 times annually for compliance and reviewed by Quality Management Team.
DISPUTE OF CITATION- the facility is requesting consideration of removal of this citation as Christ the King Manor followed a thorough screening process prior to the hiring of Staff A. In the application of employment, it is required to disclose any prior criminal charges, and initial phone screen is conducted, then an in-person screening, references are checked along with a criminal background check. There was no evidence of a prior issues or potential issues of misconduct noted. Once Christ the King Manor was made aware of the occurrence, the Personal Care Administrator contacted Department of Human Services, AAA, Protective services, Police Department and conducted education with all current staff members and residents. Staff A was terminated prior to learning of the occurrences. The facility has a ZERO tolerance rule on any conduct of this type and we are asking for consideration to remove this citation.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 10/09/2025)

85d - Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/1/25 at 12:00 p.m., the lid to the garbage can was pushed to the side, and garbage was on the floor of the men's common bathroom by the administrative offices.

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Plan of Correction ***Accept ([redacted] - 09/18/2025)***

3. 2600.85d
It is our intent that trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent penetration of insects and rodents.
The trash can in the men's bathroom by the administrative hall was emptied immediately on 07-01-2025 and all staff was educated to check the garbage in all bathrooms every shift, after hours of business and/or when housekeeping is not available. Signage with a checklist was posted in the restrooms with a cleaning date and time. Housekeeping will collect the checklist weekly for 1 month then monthly for 3 months and report it to the Personal Care Administrator.
This will be reviewed by our Quality Management Team.

Licensee's Proposed Overall Completion Date: *09/18/2025*

Implemented ([redacted] - 10/09/2025)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

88a - Surfaces *(continued)*

Description of Violation

On 7/1/25 at 12:15 p.m., there was an approximate 5' X 2' puddle of water on the floor in the mechanical room between personal care and the secure dementia care unit.

Plan of Correction ***Directed (- 09/18/2025)***

3. 2600.85d

It is our intent that trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent penetration of insects and rodents.

The trash can in the men's bathroom by the administrative hall was emptied immediately on 07-01-2025 and all staff was educated to check the garbage in all bathrooms every shift, after hours of business and/or when housekeeping is not available. Signage with a checklist was posted in the restrooms with a cleaning date and time. Housekeeping will collect the checklist weekly for 1 month then monthly for 3 months and report it to the Personal Care Administrator.

This will be reviewed by our Quality Management Team.

Proposed Overall Completion Date: 09/18/2025

Directed:

By 9/20/25, the administrator or designee will ensure the 5' X 2' puddle of water on the floor in the mechanical room between personal care and the secure dementia care unit is cleaned up and the floor is dry. Documentation will be kept.

[redacted] *9/18/25*

Directed:

By 9/30/25, the administrator will determine the root cause and take all necessary action to resolve the problem. Documentation will be kept.

[redacted] ***9/18/25***

Directed:

By 9/30/25 and monthly thereafter, the administrator or designee will inspect the home to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Documentation will be kept.

[redacted] ***9/18/25***

Directed Completion Date: *09/30/2025*

Implemented (- 10/09/2025)

91 - Telephone Numbers

5. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 7/1/25 at 11:30 a.m., there were no emergency telephone numbers, to include the nearest hospital and fire department, on or by the telephone in the personal care kitchenette.

91 - Telephone Numbers *(continued)*

Plan of Correction ***Accept (- 09/18/2025)***

5. 2600.91
It is our intent that Emergency telephone numbers for the nearest hospital, police department, fire department ambulance, poison control local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.
The list of required phone numbers was immediately posted in the personal care kitchen on 07-01-2025.
The Housekeeper will check all rooms for the emergency lists to ensure they are posted by every land line phone weekly for 1 month then monthly for 3 months and upon all new admissions and report to the administrator.
We will review with our Quality Management Team

Licensee's Proposed Overall Completion Date: *09/18/2025*

Implemented (- 10/09/2025)

102i - Soap Dispenser

6. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 7/1/25 at 11:50 a.m., there was an unlabeled bar of soap in the community shower room of the secure dementia care unit.

Plan of Correction ***Accept (- 09/18/2025)***

6. 2600.102.i. It is our intent to provide each sink with a soap dispenser within reach of each bathroom sink. Bar soap is not permitted unless separate bars are clearly labeled for each resident who shares a bathroom.
The unlabeled bar soap was immediately removed from the community bathroom on 7/1/25.
Wellness director will inspect all community bathrooms weekly for 4 weeks, then monthly for two months to ensure that liquid soap remains stocked and labeled and any bar soap is individually labeled in a single soap container.
We will review with our Quality Management Team.

Licensee's Proposed Overall Completion Date: *09/18/2025*

Implemented (- 10/09/2025)

103f - Refrigerator/Freezer Temps

7. 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 7/1/25 at 11:45 a.m., there was no thermometer in the freezer section of the white refrigerator/freezer in the personal care activity room.

Plan of Correction ***Accept (- 09/15/2025)***

103f - Refrigerator/Freezer Temps (continued)

7. 2600.103f
It is our intent that food requiring refrigeration shall be stored at 40-degree f. Frozen food shall be kept at or below 0 f. Thermometers are required in refrigerators and freezers.
The thermometer was found in the back of the freezer on 7/1/25 and reported to the inspector.
Housekeeping will document presence of thermometers in the café refrigerator daily and will report to our administrator for 4 weeks.
We will review in our quality management meeting.

Licensee's Proposed Overall Completion Date: *10/10/2025*

Implemented ([redacted] - 10/09/2025)

132c - Fire Drill Records

8. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill log indicates the following:

On 4/18/25 at 5:30 a.m., there were 54 residents in the home; however 52 residents evacuated.

On 5/5/25 at 2:35 p.m., there were 60 residents in the home; however, 50 residents were evacuated.

On 6/2/25 at 10:30 a.m., there were 61 residents in the home; however, 52 residents were evacuated.

Plan of Correction ***Directed ([redacted] - 09/18/2025)***

8.02600.132c
It is our intent that a written fire drill includes the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.
We will document all residents evacuated in total including the personal care unit and our secured unit instead of separating units per the suggestion of the inspector.
We will review with our Quality Management Team.

Proposed Overall Completion Date: 09/18/2025

Directed:
By 9/30/25 and monthly thereafter, the administrator or designee will review the fire drill log following every fire drill, to ensure it accurately documents the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative. Documentation will be kept.

132c - Fire Drill Records (continued)

[redacted] ***9/18/25***

Directed Completion Date: *09/30/2025*

Implemented ([redacted] - 10/09/2025)

187b - Date/Time of Medication Admin.

9. 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 #3 is prescribed Gabapentin 100mg capsule, take 1 capsule in the afternoon. However, on 6/18/25 at 2:00 p.m., the staff person administering the medication did not initial the resident's June 2025 medication administration record.

Resident #4 is prescribed 1 to 2 drops of Thera-tears 0.25% solution, instill into affected eyes daily; however, from 6/1/25 to 7/1/25 the staff administering the medication did not initial the resident June and July 2025 medication administration record at the time of administration.

Plan of Correction ***Accept ([redacted] - 09/18/2025)***

9.2600.187b
It is our intent is to document and record all medication at the time it is administered.
All trained staff were re-educated on the facility policy and regulations requiring immediate documentation on the MAR at the time of medication administration.
Wellness director will conduct random MAR audits daily for two weeks, then weekly for one month to ensure compliance and will reeducate as needed ongoing.
We will review with our Quality Management Team

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 10/09/2025)

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's annual assessment, dated [redacted], indicates the resident does not need assistance with transferring in/out of bed/chair. However, the resident uses a mobility device. Resident #3's assessment does not identify the specific device to be used, the resident's need for an enabler bar attached to the resident's bed, the intended use and risks

225c - Additional Assessment (continued)

associated with the use, the resident's ability to use the device safely, and whether a cover is required to meet FDA guidelines.

Resident #5's annual assessment, dated [redacted] indicates the resident does not need assistance with transferring in/out of bed/chair. However, the resident uses a mobility device. Resident #5's assessment does not identify the specific device to be used, the resident's need for an enabler bar attached to the resident's bed, the intended use and risks associated with the use, the resident's ability to use the device safely, and whether a cover is required to meet FDA guidelines.

Resident #6 has had an increase in aggressive behavior and has made multiple unfounded accusations of staff stealing [redacted] money. However, the resident's annual assessment, dated [redacted], does not address these changes in condition.

Plan of Correction ***Accept ([redacted] - 09/15/2025)***

11. 2600.225c
It is our intent is to complete written assessments within 15 days of admission and update assessments to reflect resident needs upon significant change and annually.
Care plan of mentioned resident was updated to reflect use of enabler bar and revised to address the residents needs of the device, intended use and risks and ability to use the device safely.
Personal Care Aide's will monitor residents daily for safe and intended use of enabler bar and report changes in condition to wellness director.
Administrative assistant will ensure annual assessments include use of enabler bar for assistance with transferring in/out of bed/chair and the ability of the resident to safely use the device.
We will review with our Quality Management Team.

Licensee's Proposed Overall Completion Date: *09/12/2025*

Implemented ([redacted] - 10/09/2025)

233c - Key-Locking Devices

12. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 7/1/25 at 12:00 p.m., the directions for operating the home's locking mechanism were not conspicuously posted near exit door #11 and the exterior activity gate in the secure dementia care unit.

Plan of Correction ***Accept ([redacted] - 09/18/2025)***

12.2600.233.c. Our intent is to provide directions that prevent immediate egress for operation for key-locking devices, electronic card systems and other devices conspicuously near each device.
On 7/1/25 it was found that door #11 and exterior activity gate in the secured dementia unit did not have directions for operating the home's locking mechanism. Directions to the mechanism were immediately posted conspicuously at door #11 and at the exterior activity gate.
All staff was always educated on requirements to maintain proper signage at all doors with a locking device.
Personal Care Aide's assigned to the secured dementia unit will inspect all exit doors weekly for 4 weeks, then monthly. Results will be documented, and corrective action taken as needed.

233c - Key-Locking Devices (continued)

We will review with our Quality Management Team.

Licensee's Proposed Overall Completion Date: *09/18/2025*

Implemented ([redacted] - 10/09/2025)