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

August 21, 2025

[redacted] , VICE PRESIDENT
HAYES MANOR INC
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131

RE: HAYES MANOR
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131
LICENSE/COC#: 14223

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/29/2025 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: *HAYES MANOR* **License #**: *14223* **License Expiration**: *10/02/2025*

Address: *2210 BELMONT AVENUE, PHILADELPHIA, PA 19131*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *HAYES MANOR INC*

Address: *2210 BELMONT AVENUE, PHILADELPHIA, PA, 19131*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *04/12/1985* **Issued By**: *Phila - L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *42* **Waking Staff**: *32*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *07/29/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *5* **Are 60 Years of Age or Older**: *37*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

07/29/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/21/2025*

08/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

Inspections / Reviews *(continued)*

08/21/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *08/21/2025*

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

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident 1, admitted [redacted], did not have a resident-home contract.

Plan of Correction ***Accept ([redacted] - 08/21/2025)***

1) Immediate Correction
• 07/30/2025: A new resident–home contract was completed with the returning Resident #1 and filed in the chart.
• 08/7/2025: Administrator and office staff reviewed the violation and verified placement of the executed contract.
2) Full Chart Audit
• 08/12/2025: Office staff completed a home-contract audit of all resident charts to confirm each resident has a signed contract on file. See attached audit list.
• 08/12/2025: As a related safeguard, office staff also verified a signed acknowledgment of Resident Rights and Complaint Procedures is present in each chart. See attached.
3) Admission Packet Review Requirement
• Effective immediately: For every new or re-admission, the Administrator or designee will review the admission packet prior to admission or within 24 hours after admission to ensure:
o Resident–home contract is reviewed with the resident/representative, questions answered, then signed.
o Signed contract is placed in the chart the same day.
4) Signature Tagging (Pre-admission Control)
• Effective 08/01/2025: Office staff will tag every required signature line in the packet (home contract, Resident Rights, Complaint Procedures) before the admission appointment, so nothing is missed. (No new admissions since this control went live.)
5) Triple-Check Verification at Admission
• Check 1 – Admissions Personnel: Confirm all required signatures are complete before forwarding the packet to the Administrator.
• Check 2 – Director of Finance: Re-verify required signatures during financial review/personal account setup at admission.
• Check 3 – Administrator/Designee: Final page-by-page review for all signatures at the time of admission, or by end of day if not available at time of admission.
6) Staff Training
• 08/07/2025: Administrator provided an in-service to all office/admissions personnel on §25a requirements (contract content, timing, signature capture, filing) and on obtaining Resident Rights/Complaint acknowledgments. Attendance sheet and materials are on file.
7) Ongoing Monitoring & Documentation
• Starting 09/01/2025: The Administrator or designee will audit all new/re-admission charts monthly to verify §25a compliance.
• Recordkeeping: Audit logs will be maintained for at least six (6) months and made available to DHS upon request. Any deficiency triggers same-day correction and re-education if needed.

Completion/Start Date
• Contract executed for Resident #1: 07/30/2025

25a - Written Contract and Review (continued)

- *Violation review by Administrator/office staff: 08/7/2025*
- *Staff in-service: 08/07/2025*
- *Chart audits completed (contracts; rights/complaints): 08/12/2025*
- *Signature tagging & triple-check implemented: 08/01/2025*
- *Monthly audits begin: 09/01/2025 (ongoing)*

This POC corrects the cited deficiency, adds multiple pre-admission and day-of-admission controls (tagging + triple-check), and institutes recurring audits to ensure sustained compliance with §25a and prevent recurrence.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented ([redacted] - 08/21/2025)

41e - Signed Statement

2. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 1's record does not have a record that contains a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 08/21/2025)***

1. Immediate Correction

o On July 30, 2025, the administrator met with Resident #1 and obtained a signed acknowledgment statement confirming receipt of resident rights and complaint procedures. This signed document has been placed in Resident #1's record.

2. Chart Audit

o On August 12, 2025, the office staff completed a full audit of all current resident charts to verify that each contains a signed acknowledgment of resident rights and complaint procedures. Copies of the audit have been attached for DHS review.

3. Staff Training / In-Service

o On August 7, 2025, the administrator conducted an in-service training for all office personnel emphasizing the

41e - Signed Statement (continued)

regulatory requirement that every new admission or re-admission must include a signed acknowledgment of resident rights and complaint procedures. Documentation of this training has been maintained.

4. Ongoing Monitoring

o Beginning September 1, 2025, the administrator or designee will review all new and re-admission charts on a monthly basis to ensure compliance with DHS regulations.

o Documentation of these monthly audits will be maintained for a minimum of six months and made available for DHS review upon request.

5. Admission Chart Review

o Effective immediately, all new and re-admission charts will also be reviewed by the administrator or assistant administrator within 30 days of admission to confirm that the signed acknowledgment is on file.

6. Implementation of Triple-Check System

To prevent future deficiencies, Hayes Manor has implemented a three-step verification process for required admission documents:

o Step 1: Admission personnel will ensure all required signatures are obtained before submitting contracts to the administrator.

o Step 2: The Director of Finance will verify required signatures during financial review and setup of resident personal accounts.

o Step 3: The administrator or designee will conduct a final review of all admission documents, confirming that every required signature is present at the time of admission.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented ([redacted] - 08/21/2025)

103f - Refrigerator/Freezer Temps

3. 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

There was no thermometer in one of the standalone freezers in the basement.

103f - Refrigerator/Freezer Temps (continued)

There was also no thermometer in the bottom freezer of one of the refrigerators in the main kitchen.

Plan of Correction ***Accept (- 08/21/2025)***

- *Immediate Correction*
  On July 30, 2025, the maintenance manager installed new thermometers in the basement standalone freezer and in the bottom freezer of the kitchen refrigerator.
  Photographs documenting the corrected placement of thermometers are enclosed for verification.
- *Staff Awareness & Training*
  On August 5, 2025, the administrator conducted an in-service training with all dietary staff regarding:
  The requirement for thermometers to be present in all refrigerators and freezers.
  Proper placement and accuracy check of thermometers.
  The importance of monitoring food storage temperatures to prevent spoilage or unsafe conditions.
  Documentation of the training is enclosed.
- *Daily Monitoring & Documentation*
- *Beginning August 1, 2025, dietary staff (with primary responsibility assigned to the cook) were instructed to:*
  -Check that all thermometers are properly in place and functioning when completing the daily temperature logs.
  -Record any discrepancies immediately and notify the administrator or maintenance manager.
  -Use replacement thermometers (readily available in the dietary office and maintenance office) if a thermometer is missing or malfunctioning.
- *Administrative Oversight*
  -As of August 1, 2025, the administrator or designee conducts daily rounds to provide a secondary observation ensuring thermometers are in place and operational.
  -Any identified issues are corrected immediately and documented.

Completion Dates

1. *Thermometers installed: July 30, 2025*
2. *Daily monitoring by dietary staff implemented: August 1, 2025*
3. *Administrator daily observation implemented: August 1, 2025*
4. *Staff in-service training conducted: August 5, 2025*
5. *This Plan of Correction ensures that all refrigerators and freezers at Hayes Manor are properly monitored with functioning thermometers and establishes a system of staff accountability and administrative oversight to prevent recurrence.*

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented (- 08/21/2025)

141a - Medical Evaluation

4. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

141a - Medical Evaluation *(continued)*

Description of Violation

Resident 1 was admitted to the home on [redacted]. However, the medical evaluation for resident 1 was not complete within 60 days prior to admission or within 30 days after admission of the resident. The medical evaluation was completed on [redacted].

Resident 2 was admitted to the home on [redacted] The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident. The medical evaluation was completed on [redacted]

Resident 3 was admitted to the home on [redacted] However, the medical evaluation for resident 3 was not complete within 60 days prior to admission or within 30 days after admission of the resident. The medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 08/21/2025)***

1) Immediate Corrections (Completed)
7/30/2025: Administrator and Nurse Manager reviewed the violation details and resident charts.
Resident #1: Current medical evaluation (completed 5/23/2025) verified, filed, and care plan updated. Next annual due 5/23/2026 (target scheduling by 4/15/2026).
Resident #2: Current medical evaluation obtained/verified on 7/30/2025 following DHS emergency admission; documentation filed and any new orders implemented.
Resident #3: Updated medical evaluation obtained/verified on 7/30/2025; filed and care plan reconciled.
Responsible: Nurse Manager; verified by Administrator.
Evidence: Copies of current evaluations and chart notes (on file for review).
2) Regulatory Reinforcement (Completed 7/30/2025)
Reiterated to clinical/admissions staff that the initial medical evaluation must be completed within 60 days prior to admission or within 30 days after admission; DHS emergency relocations must still meet the 30-day post-admission requirement.
If a primary physician is unavailable, staff must use a qualified alternate (PA/NP/another MD) to meet deadlines—no exceptions.
Responsible: Administrator [redacted]
3) Proactive Scheduling & Escalation (Implemented 8/1/2025)
Standard process:
Planned admissions: Request evaluation 60 days prior to the anticipated admission date; repeat request at 30 days prior if not received.
Emergency/DHS closures: Schedule evaluation within 5 business days of admission; hard deadline = 30 days post-admission.
Escalation: If not scheduled by Day 10 post-admission (or 30 days prior for planned admissions), Nurse Manager notifies Administrator; alternate provider is engaged the same day.
Responsible: Nurse Manager initiates; Administrator oversees.
4) Tracking & Documentation (Implemented 8/1/2025)
Created an Initial & Annual Medical Evaluation Tracking Log (resident name, admission date, eval due window, requests sent at 60/30 days, appointment date, completion date, provider, exceptions/escalations).
Log reviewed weekly by the Nurse Manager and monthly by the Administrator.
5) Staff Training / In-Service (Completed 8/6/2025

141a - Medical Evaluation (continued)

In-service for admissions, nursing, and administrative staff covering 141a/141b requirements, timelines, escalation pathways, and documentation standards.
Attendance and materials maintained on file.
Responsible: Administrator.
6) Retrospective Audit (Completed 8/8/2025)
Nurse Manager audited all resident charts for 141a compliance (60-day prior / 30-day post).
Any deficiencies identified were corrected and documented; corrective actions logged.
Responsible: Nurse Manager; Administrator reviewed results.
7) Ongoing Monitoring & QA (Effective August 2025)
Monthly check: Nurse Manager cross-checks the tracking log during medication recap (recaps commence around the 25th each month).
Admission date: Administrator or designee reviews all new admission packets 24 hours prior to admission to confirm a qualifying evaluation is on file or scheduled within 30 days (for emergencies).
Quarterly review for one year: Administrator or designee conducts a quarterly spot audit of all residents' initial/annual evaluation compliance.
Stop-admission rule: Admissions may be deferred if a qualifying evaluation cannot be confirmed or scheduled within regulatory timeframes.
Completion Dates
Violation review: 7/30/2025
Immediate chart corrections/verification: 7/30/2025
Process & tracking implementation: 8/1/2025
Staff in-service: 8/6/2025
Full chart audit: 8/8/2025
Ongoing monitoring: August 2025 and continuing
This POC corrects the cited cases (Residents #1–#3), installs proactive scheduling with escalation, strengthens admission gatekeeping, and adds layered monitoring to prevent recurrence and ensure full compliance with 141a.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented ([redacted] - 08/21/2025)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information *(continued)*

Description of Violation

Resident 1's medical evaluation dated [redacted] did not include special health or dietary needs of the resident.

Resident 3's medical evaluation dated [redacted] did not include a general physical examination by a physician, physician's assistant, or nurse practitioner; allergies; or body positioning and movement stimulation for residents, if appropriate.

Plan of Correction ***Accept ([redacted] - 08/21/2025)***

1) Immediate Review of Violations
On 7/30/2025, the administrator and nurse manager reviewed the cited violations and confirmed missing required components in Residents #1 and #3's medical evaluations.
2) Correction of Missing Information
On 7/31/2025, the nurse manager contacted:
Resident #1's PCP to obtain the missing information regarding special health and dietary needs.
Resident #3's provider to obtain the missing examiner signature, allergy information, and body positioning details.
Updated evaluations were received, corrected, and filed in the residents' charts.
3) Chart Audit of All Residents
By 8/8/2025, the nurse manager completed a full audit of all resident medical evaluations to verify compliance with 141a(1–10), including:
Examiner's signature
Current medical diagnoses
Health status and medical information
Special dietary needs
Allergies
Immunization history
Medication regimen (including contraindications and side effects)
Body positioning and mobility needs
Any deficiencies were corrected immediately. Documentation of this audit is on file for DHS review.
4) Staff In-Service Training
On 8/6/2025, the administrator conducted an in-service with all nursing staff regarding:
Requirements under 141a(1–10) for medical evaluation documentation.
Steps to follow when receiving incomplete evaluations (return to provider for correction before filing).
Attendance records and training materials are maintained.
5) Implementation of Medical Evaluation Checklist
On 8/1/2025, the nurse manager implemented a Medical Evaluation Requirement Checklist to be used:
At every new admission.
At each annual medical evaluation.
Any evaluation missing required elements will be immediately returned to the provider for correction prior to placement in the chart.
6) Ongoing Monitoring – Monthly & Quarterly
Monthly: The nurse manager will review all current medical evaluations during medication renewal recaps (beginning the 25th of each month) as a second check for compliance.

141a 1-10 Medical Evaluation Information (continued)

Quarterly: The administrator or designee will review all resident medical evaluations upon admission and quarterly for one year to ensure all 141a(1–10) requirements are consistently met.

Completion Dates
Review of violation: 7/30/2025
Missing information requested & corrected: 7/31/2025
Medical evaluation checklist implemented: 8/1/2025
Staff in-service conducted: 8/6/2025
Full chart audit completed: 8/8/2025
Ongoing monitoring: August 2025 and continuing

? This POC corrects the immediate deficiencies, adds a standardized checklist, and installs layered monitoring (monthly and quarterly) to ensure compliance with all requirements of 141a(1–10) and to prevent recurrence.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented (- 08/21/2025)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 3's most recent medical evaluation was completed on 3/06/2025. The resident's previous medical evaluation was completed on 2/01/2024.

Plan of Correction ***Accept (- 08/21/2025)***

1. Immediate Review of Violation
o On 7/30/2025, the administrator and nurse manager reviewed the violation and confirmed that Resident #3's annual medical evaluation was not completed within the required timeframe.
o The requirements were discussed: medical evaluations must be completed within 60 days prior to admission or within 30 days after admission and annually thereafter.
2. Clarification of Compliance Requirements
o On 7/30/2025, the administrator instructed the nurse manager that there are no exceptions to the regulation.
o If a resident's primary physician is unavailable, the nurse manager must ensure the evaluation is completed by a physician assistant, nurse practitioner, or another licensed physician within the required timeframe.
3. Proactive Scheduling Process
o The nurse manager will now send out requests for annual medical evaluations 60 days prior to the due date.
o If not received, the request will be repeated at 30 days prior to the due date to ensure evaluations are completed on time.
4. Staff Training
o On 8/6/2025, the administrator conducted an in-service training for all nursing staff regarding:
? Regulations for annual medical evaluations (DME).
? The requirement for documentation within the regulatory timelines.

141b1 - Annual Medical Evaluation (continued)

? Corrective measures related to 141a and 141b.
o Training documentation has been maintained for compliance verification.
5. Chart Documentation
o On 7/30/2025, the nurse manager documented Resident #3's current medical evaluation, ensuring a clear tracking system to prevent recurrence with the same resident.
6. Comprehensive Chart Audit
o On 8/8/2025, the nurse manager completed an audit of all resident charts to verify compliance with the 60-day prior / 30-day after regulation for medical evaluations.
o Audit results are on file for DHS review.
7. Ongoing Monitoring
o Beginning August 2025, the nurse manager will review all annual medical evaluations monthly during medication renewal recaps (typically starting on the 25th of each month).
o The administrator or designee will also review all resident medical evaluations upon admission and quarterly for one year to confirm compliance.
Completion Dates
• Review of violation completed: 7/30/2025
• Staff training conducted: 8/6/2025
• Resident chart audit completed: 8/8/2025
• Proactive scheduling and monitoring process implemented: August 2025 and ongoing
? This Plan of Correction ensures annual medical evaluations are completed within required timeframes, establishes multiple monitoring systems, and provides administrative oversight to prevent recurrence

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented ([redacted] - 08/21/2025)

182b - Prescription Medication

7. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 7/28/2025 at 8:00 am and 5:00 pm staff person A administered medications to residents to include the following; Lorazepam 0.5 MG to resident 4. Staff person A is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept ([redacted] - 08/21/2025)***

1) Immediate Actions (Completed)
7/29/2025: Administrator met with the Nurse Manager and Staff A to review the violation and the facility's Medication Administration Policy.

182b - Prescription Medication (continued)

7/29/2025: Staff A was immediately removed from all medication administration duties until verification of medication training received. Received from trainer on 8/1/2025 when [redacted] came in to train the staff. (pls. see attached)
7/29/2025: The Nurse Manager reviewed all resident MARs and PRNs for 7/29/2025 to confirm no medication errors occurred; none were identified. Findings were documented in a QA note.
Responsible: Administrator; Nurse Manager.
Evidence on File: Incident note, staff counseling acknowledgment, 7/29/2025 MAR review log.

2) Training & Re-Credentialing (Completed)
Staff A received verification of [redacted] training in 6/2025, a copy in on hand in [redacted] employee file, verified by administrator on 8/1/2025.
8/01/2025: All other medication staff were re-certified by a certified trainer (didactic + practicum competency). Copies of re-cert included.
No staff may resume med pass without current verification.
Responsible: Nurse Manager; Certified Trainer.
Evidence on File: In-service roster, trainer credentials, individual certificates, competency checklists.

3) Scheduling & Access Controls (Implemented 8/01/2025)
The Nurse Manager will only schedule staff for medication administration who have current, verifiable medication administration training/competency.
Med-cart keys and eMAR access are issued only to staff with active certification (verified at each shift assignment).
Responsible: Nurse Manager; Administrator (oversight).
Evidence on File: Daily med-pass roster with verification check, key control log/eMAR access list.

4) Documentation & Certificate Management (Completed/Standardized)
8/01/2025: Copies of all active medication administration training/competency certificates are maintained in a dedicated binder at the nurse's station for quick verification by management and auditors; digital copies are also retained.
8/01/2025: Human Resources (HR) received copies of all certificates and serves as a secondary monitor for expirations.
Responsible: Nurse Manager (binder); HR (personnel files, expiry tracking).
Evidence on File: Certificate binder index; HR receipt log.

5) Ongoing Monitoring & Recertification
HR semi-annual audit: HR will review certification status twice yearly; next audit scheduled January 2026(then every July/January thereafter).
Nurse Manager spot-checks: Weekly spot-checks of med pass assignments and certificate validity for 4 weeks (through 8/29/2025), then monthly thereafter.
QA review: Medication certification compliance becomes a standing item on the monthly QA meeting agenda; any lapse triggers immediate removal from med pass and corrective training.
Responsible: HR; Nurse Manager; Administrator (QA chair).
Evidence on File: HR audit log, spot-check forms, QA minutes.

6) Policy Reinforcement & Staff Communication (Completed)
Policy updated to require pre-assignment verification of training before any med pass duties.

182b - Prescription Medication (continued)

All medication staff re-educated on 8/01/2025 regarding 182b requirements, escalation steps, and consequences for non-compliance. Staff signed attendance/acknowledgment.
Responsible: Administrator; Nurse Manager.
Evidence on File: Updated policy, in-service materials, signed acknowledgments.

Completion Dates
Violation review & removal from duty: 7/29/2025
Retrospective MAR review (no errors found): 7/29/2025
Staff re-certification completed: 8/01/2025
Scheduling/access controls implemented & certificate binder set up: 8/01/2025
HR secondary monitoring initiated: 8/01/2025 (next audit January 2026)
Policy reinforcement & staff education: 8/01/2025
Ongoing monitoring: Weekly through 8/29/2025, then monthly thereafter.
This POC immediately corrected the deficiency, verified resident safety, and installed layered controls—training, scheduling gates, access restrictions, documentation, and recurring audits—to ensure sustained compliance with 182b and prevent recurrence.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented (- 08/21/2025)

224a - Preadmission Screen Form

8. 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 1 was admitted to the home on ; however, the resident does not have a preadmission screening form.

Plan of Correction ***Accept (- 08/21/2025)***

Immediate Correction
On 7/30/2025, the nurse manager completed a pre-screening form for Resident #1.
The form was placed in Resident #1's chart to correct the deficiency.
Review of Violation
On 8/6/2025, the administrator and nurse manager reviewed the violation (issued 7/29/2025) and confirmed corrective actions were required to ensure ongoing compliance with the 30-day prior regulation for pre-admission screening.
Comprehensive Chart Audit
On 8/8/2025, the nurse manager completed an audit of all resident charts to verify that pre-screening forms were completed and filed correctly.
Documentation of this audit is available for DHS review.
Admission Review Process
Effective 8/1/2025, the administrator or designee will review all new admission information 24 hours prior to admission to ensure that pre-screening forms are completed and filed.
There have been no new admissions since implementation.

224a - Preadmission Screen Form (continued)

Ongoing Monitoring by Nurse Manager
Beginning August 2025, the nurse manager will review all pre-admission screening forms monthly, during the medication renewal recaps (which typically begin on the 25th of each month).
Quarterly Administrative Oversight
The administrator or designee will review pre-admission screens for all residents upon admission and quarterly for one year to ensure compliance and prevent recurrence of this violation.
Completion Dates
Pre-screening for Resident #1 completed: 7/30/2025
Review of violation by administrator & nurse manager: 8/6/2025
Audit of all resident charts completed: 8/8/2025
Admission review process implemented: 8/1/2025 (ongoing)
Monthly and quarterly monitoring process implemented: August 2025 (ongoing)

? This Plan of Correction corrects the missing pre-screen form for Resident #1 and implements multiple safeguards (chart audits, pre-admission checks, monthly reviews, and quarterly oversight) to ensure full compliance with 224a going forward.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented ([redacted] - 08/21/2025)

252 - Record Content

9. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.

252 - Record Content *(continued)*

17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 1's most recent date of admission is [redacted]. The resident moved in initially on [redacted] and moved out of the home on an unknown date. Resident 1 moved back into the home on [redacted] The home does not have a record of the resident's previous discharge.

Plan of Correction ***Accept ([redacted] - 08/21/2025)***

1) Immediate Review of Violation

• On 7/31/2025, the administrator and nurse manager reviewed the violation and identified the absence of a discharge record for Resident #1.

• Resident #1's chart was updated with a written addendum documenting [redacted] and subsequent return to Hayes Manor.

2) Policy Development

• A new Discharge and Leave of Absence Policy was developed to distinguish between:

o Formal Discharge: The resident's chart is closed, and services are considered terminated. A discharge summary must document permanent move, reason for discharge, forwarding address, contact person, and care arrangements.

o Leave of Absence (LOA): The resident temporarily leaves but remains on the roster. An LOA form must document expected return date (if known), temporary location, reason for leave, responsible contact person, and any interim care arrangements.

3) Staff Training

• On 8/6/2025, the administrator conducted an in-service with all nursing and administrative staff on the new Discharge and LOA Policy, including documentation requirements.

• Staff signed acknowledgment forms confirming understanding of the policy.

4) Chart Audit

• On 8/8/2025, the nurse manager conducted an audit of all current residents' charts to verify that discharge records and/or leave of absence documentation were present where applicable.

• Any deficiencies identified were corrected immediately. Documentation of the audit is on file.

5) Implementation of New Forms

• Standardized Discharge Form and Leave of Absence Form were created and implemented on 8/10/2025.

• These forms must be completed by the nurse manager or designee for any resident leaving the facility, whether temporarily (LOA) or permanently (discharge).

6) Ongoing Monitoring

• Beginning August 2025, the administrator or designee will review all discharges and LOAs on a monthly basis to ensure documentation is complete.

• Discharge and LOA compliance will be a standing item on the quarterly QA meeting agenda.

252 - Record Content (continued)

Completion Dates

- *Review of violation: 7/31/2025*
- *Resident chart updated: 7/31/2025*
- *Policy developed: 8/01/2025*
- *Staff in-service conducted: 8/06/2025*
- *Chart audit completed: 8/08/2025*
- *New discharge/LOA forms implemented: 8/10/2025*
- *Monthly/quarterly monitoring: August 2025 and ongoing*

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented ([redacted] - 08/21/2025)