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

September 25, 2025

[redacted]
RAPPS SENIOR CARE LLC
[redacted]
ATTN BILL SNOW
[redacted]

RE: WOODBRIDGE PLACE
1191 RAPPS DAM ROAD
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14359

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/31/2025 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: *WOODBRIDGE PLACE* **License #**: *14359* **License Expiration**: *12/21/2025*

Address: *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *RAPPS SENIOR CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/01/1996* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *115* **Waking Staff**: *86*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *07/31/2025*

Inspection Dates and Department Representative

07/31/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lilac* **Capacity**: *21* **Residents Served**: *12*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *82*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *33*

Have Physical Disability: *0*

Inspections / Reviews

07/31/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/30/2025*

08/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/25/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/03/2025*

Inspections / Reviews *(continued)*

09/04/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/25/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/26/2025*

09/25/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/25/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] at 10:03 am there was a signage on the door to enter resident [redacted]s room that read "Resident requires supervision with power wheelchair mobility."

Plan of Correction ***Directed [redacted] - 09/04/2025)***

On 7/31/2025 the "Resident requires supervision with power wheelchair mobility." sign was relocated from outside of resident's apartment to inside. Effective August 27, 2025 Executive Director or [redacted] designee will conduct weekly audits of entire community to ensure there is no protected health information in public view. This audit will be continued through October 1, 2025.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date: *09/24/2025*

Implemented [redacted] - 09/25/2025)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, hired [redacted], did not have a criminal background check completed until [redacted]

Staff person B, hired [redacted], did not have a criminal background check completed until [redacted]

Plan of Correction ***Directed [redacted] 09/04/2025)***

On 8/1/2025 an email was submitted to DHS containing Staff person A's original background check dated 4/3/2023. Please see attached.
Effective 8/20/2025 all agency staff are required to have a PATCH background check prior to being eligible to work in the community.
Audit of all associate files to be completed by Business Office Director by 9/30/2025. Business Office Director to audit agency workers and new associate files weekly to ensure compliance with regulation 2600.51 beginning 9/1/2025 to November 1, 2025.

51 Criminal Background Check (continued)

Proposed Overall Completion Date: 11/01/2025

Directed Completion Date

Directed Completion Date: *09/24/2025*

Implemented [redacted] - 09/25/2025)

65e - 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person C received only 8 hours of annual training in the training year 2024.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Staff Member C resigned 8/26/2025 to pursue other employment opportunities.
Schedule of training implemented by Business Office Director on 7/01/2025 to ensure all associates have completed 12 hours of annual training related to their job duties prior to end of year 2025.
Annual training calendar implemented and posted on 7.01.2025.
Business Office Director to continue the audit of training of staff monthly which began on July 1, 2025 through October 1, 2025 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 09/25/2025)

65f - Training Topics

4. Requirements

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

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 C did not receive training the following training during training year 2024:

- *Safe Management Techniques*

65f - Training Topics (continued)

- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

Staff Member C resigned 8/26/2025 to pursue other employment opportunities.
Schedule of training implemented by Business Office Director on 7/01/2025 to ensure all associates have completed 12 hours of annual training related to their job duties prior to end of year 2025.
Annual training calendar implemented and posted on 7.01.2025.
Business Office Director to continue the audit of training of staff monthly which began on July 1,2025 through October 1, 2025 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented ([redacted] - 09/25/2025)

65g - Annual Training Content

5. 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 C did not receive training on the following topics during training year 2024:

- *Fire Safety completed by a Fire Safety Expert*
- *Emergency Preparedness Procedures*
- *Resident Rights*
- *Falls and Accident Prevention*
- *New population groups that are being served at the home that were not previously served, if applicable.*

Staff person D did not receive training on the following topics during training year 2024:

- *Emergency Preparedness Procedures*
- *New population groups that are being served at the home that were not previously served, if applicable.*

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Staff Member C resigned 8/26/2025 to pursue other employment opportunities.
Staff Member D is inactive/on leave due to a work comp case.
Schedule of training implemented by Business Office Director on 7/01/2025 to ensure all associates have completed 12 hours of annual training related to their job duties prior to end of year 2025.
Annual training calendar implemented and posted on 7.01.2025.
Business Office Director to continue the audit of training of staff monthly which began on July 1, 2025 through October 1, 2025 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented ([redacted] - 09/25/2025)

95 - Furniture and Equipment

6. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The keypad used to operate the Stairwell 3, Door 1 exit in the Secured Dementia Care Unit was malfunctioning.

Plan of Correction ***Directed [redacted] - 09/04/2025)***

On 7/31/2025, Maintenance Director repaired the keypad in memory care immediately and confirmed operability to the Executive Director.
Maintenance Director to audit all memory care keypads starting on August 1, 2025 for compliance weekly and this audit will be completed by 10/01/2025.

Executive Director or [redacted] designee to spot check keypads in memory care neighborhood bi-weekly to ensure operability.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date: *09/24/2025*

Implemented [redacted] - 09/25/2025)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted], an inoperable keypad blocked egress from the home's Secured Dementia Care Unit in Stairwell 3 at Door 1.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Directed [redacted] 09/04/2025)***

On 7/31/2025, Maintenance Director repaired the keypad in memory care immediately and confirmed operability to the Executive Director.
Maintenance Director to audit all memory care keypads starting on August 1, 2025 for compliance weekly and this audit will be completed by 10/01/2025.
Executive Director or [redacted] designee to spot check keypads in memory care neighborhood bi-weekly to ensure operability.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date: *09/24/2025*

Implemented [redacted] - 09/25/2025)

131f - Fire Extinguisher Inspection

8. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the designated smoking area did not have an inspection tag.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

On 7/31/2025 an inspection date was added to the fire extinguisher in question by the Maintenance Director.
The Maintenance Director is to audit all fire extinguishers in the community for compliance of inspection dates to start on August 1, 2025 and this audit will be completed by 9/2/2025.
Executive Director and/or [redacted] designee will also spot check bi-weekly the tags on the extinguishers in the community to ensure compliance until 9/2/25.

Licensee's Proposed Overall Completion Date: *09/02/2025*

Implemented ([redacted] - 09/25/2025)

162c - Menus Posted

9. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] the home's menu for the current week and following week was not posted in the Secured Dementia Care Unit.

Repeated Violation: [redacted]

162c - Menus Posted *(continued)*

Plan of Correction ***Directed [redacted] - 09/04/2025)***

On 7/31/2025 menus were immediately posted in the Secured Dementia Care Unit.
Wall mounted frames have been installed in the Secured Dementia Care Unit to house the weekly menus. (see attached)
Memory Care Director to conduct audits every two weeks to ensure compliance with regulation 2600.162.c through October 31, 2025.

Proposed Overall Completion Date: 10/31/2025

Directed Completion Date: *09/24/2025*

Implemented [redacted] - 09/25/2025)

183e - Storing Medications

10. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident [redacted] is prescribed [redacted] injection. On [redacted] the [redacted] injection pen with an open date of [redacted] was still available on the medication cart. According to the manufacturer's instructions, the medication should be discarded 28 days after opening.

Resident [redacted] is [redacted]. On [redacted], the [redacted] was available on the medication cart without an open date. According to the manufacturer's instructions, the medication should be discarded 90 days after opening.

Repeated Violation: [redacted] et al.

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

Resident [redacted] s[redacted] pen was immediately order from the pharmacy and arrived by the next business day. An open date was put on the insulin pen for compliance. Resident [redacted] s eye drop was ordered and arrived the next business day. An open date was put on the eye drop to meet compliance.
Continued weekly cart audits to be conducted by DOW or [redacted] designee to ensure compliance of all insulin pens being discarded within 28 days after opening as well as checking that all eye drops have open dates and that they are all discarded within 29 days.
Weekly med cart audits, x3 months will be put in place starting July 7, 2025, through September 2, 2025.

Licensee's Proposed Overall Completion Date: *09/02/2025*

Implemented [redacted] - 09/25/2025)

185a - Implement Storage Procedures

11. Requirements

185a - Implement Storage Procedures *(continued)*

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 resident [redacted] has a physician order for blood sugar checks as needed. On [redacted] the resident's glucometer read [redacted] at 8:25pm and on [redacted] the resident's glucometer read [redacted] at 8:05pm. However, the staff person did not record the resident's blood sugar readings on the resident's July 2025 medication administration record (MAR).

Plan of Correction ***Accept [redacted] - 09/04/2025)***

On August 3, 2025, the med. tech who did not transcribe the accu-check number was again in-serviced on the proper documentation of blood sugar readings into the EMAR.

The In-service that was conducted for the medication technicians, DOW and staff LPN starting on June 30, 2025, was completed for all medication technicians by July 9, 2025. The in-service was to educate the staff members on regulation 2600.185.a highlighting proper documentation from the glucometer reading of a blood sugar to the transcribing of that number into the MAR. (This In-service will be available to the Department upon request).
Weekly glucometer audits were put into place on June 30, 2025. The glucometer audit form will be used to check 5 various residents glucometer readings and compare that number to the number documented in the MAR, 1x weekly. This audit will be conducted by the DOW or [redacted] designee.
The in-service and the glucometer audit forms will be available for the Department to review per request. This weekly audit will be completed on September 1, 2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 09/25/2025)

12. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] is prescribed [redacted], apply topically to affected area 3 – 4 times daily as needed. On [redacted] the medication was not available in the home.

Resident [redacted] is prescribed [redacted], take 1 tablet by mouth every 4 hours as needed. On [redacted], the medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

On 8/1/25, the pharmacy was contacted by the staff nurse and the [redacted] for resident [redacted] as well as resident [redacted] were ordered and were available for the residents that evening.
Weekly med cart audits will continue through October 7, 2025. The DOW or [redacted] designee will conduct the weekly cart audit to ensure that all medications are available to be administered by the doctor's order.
The in-services that were completed and documented will be available upon review when requested.

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 09/25/2025)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident [redacted] has a prescriber's order for fasting blood sugar checks daily at 8:00am. However, the resident's blood sugar was checked after the required time on the following dates:

[redacted]

Repeated Violation: [redacted] et al.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

On August 1, 2025, immediate re-education was provided to the DOW in regards to regulation 2600.187d so that [redacted] can successfully train the nursing staff and med. techs to ensure that compliance is met with this regulation.

An in-service was conducted on August 4, 2025 by the DOW pertaining to regulation 2600.187.d. The training included all staff nursing as well as all med techs. The in-service educated the staff on the importance of following the direction of the prescriber within the eMAR and on all labels of the medications.
Weekly glucometer audits were put into place on June 30, 2025. The glucometer audit form will be used to check 5 various residents glucometer readings and compare that number to the number documented in the MAR, 1x weekly as well as verify the correct time of the accu-check. This audit will continue to be conducted by the DOW or [redacted] designee to be completed by September 1, 2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 09/25/2025)

14. Requirements

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

Description of Violation

Resident [redacted] has a prescriber's order for [redacted], using 20 units at bedtime. However, on [redacted] at 5:03pm the medication was not available in the home and the home was using the expired [redacted]

187d - Follow Prescriber's Orders (continued)

[redacted] for this administration. Per staff person, the medication will be ordered on [redacted] but will not arrive until [redacted]

Repeat Violation: [redacted]

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

On 7/31/25, immediately removed and discarded the expired insulin pen off the cart as to not have it used in future.
On 7/31/2025 staff nurse placed an order for the expired insulin that was on the medication cart for resident [redacted] The ordered insulin arrived at the community on August 1, 2025.
An in-service was conducted on August 4, 2025 by the DOW pertaining to regulation 2600.187.d. The training included all staff nursing as well as all med techs. The in-service educated the staff on the importance of following the direction of the prescriber within the eMAR and on all labels of the medications. This in-service also included the importance of verification of expiration dates of the insulin pens on the medication carts.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 09/25/2025)

225a - Assessment 15 Days

15. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [redacted] assessment, dated [redacted], does not include the resident's need for a walker and rollator.

The assessment for Resident [redacted] dated [redacted], does not include the resident's medical diagnosis and the resident's dietary needs are checked off as none. However, the resident's most recent medical evaluation dated [redacted] indicates the resident has a hearty healthy and non-concentrated sweets.

Repeated Violation: [redacted] et al.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

On 8/26/25 the Administrator educated the Director of Wellness on regulation 2600.225a so that [redacted] could further educate [redacted] nursing team on the regulation.

On 8/27/2025 Administrator updated Resident [redacted]s assessment with an addendum to clarify the need for a walker and rollator. The assessment for resident [redacted] was updated by Administrator on 8/27/202 to include the medical diagnosis and dietary needs of the resident to be shown on the assessment.
Audit started by Administrator on 8/1/2025 of all resident assessments to ensure that all needs of the residents are being captured. This audit will be completed on all assessments by 9/1/2025.
Administrator to spot check all new move in charts to ensure that the assessments are in compliance with the Department.

225a - Assessment 15 Days (continued)

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented (- 09/25/2025)

16. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident was admitted on however, the resident's assessment was not completed until

Plan of Correction ***Accept (- 09/04/2025)***

Administrator audited resident record on which did show a completed assessment for resident dated 6/5/2025 which is in compliance. I respectfully ask that this resident's assessment be reviewed to ensure compliance and this citation be removed.
Audit started by Administrator on 8/1/2025 of all resident assessments to ensure that all needs of the residents are being captured. DOW was educated also on this date to ensure is aware and can train team on the regulation. This audit will be completed on all assessments by 10/1/2025. Covered with this audit will be that the DME date, assessment dates and prescreen dates are all in compliance.
The Administrator will monitor all new residents charts the day after their move in to check that all paperwork, ie DME, Pre-Screen and Rasps are completed and in compliance per the regulations.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented 09/25/2025)

227d - Support Plan Medical/Dental

17. 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

The assessment for resident dated indicates the resident has a need for assistance with mobility, ambulation and requires extensive supervision. On , the agent of the department observed signage on the entrance of the resident's bedroom door that read "Resident requires supervision with power wheelchair mobility." However, the resident's support plan, dated , does not mention the use of the power wheelchair.

Repeated Violation et al.

Plan of Correction ***Accept - 09/04/2025)***

Administrator audited resident record on 8/4/2025 which did show a completed assessment for resident dated

227d - Support Plan Medical/Dental (continued)

12/10/2024 which did indicate under "mobilitity" [redacted] use of a power wheelchair. I respectfully ask that this resident's assessment be reviewed to ensure compliance and this citation be removed.
Audit started by Administrator on 8/1/2025 of all resident assessments to ensure that all needs of the residents are being captured. This audit will be completed on all assessments by 9/1/2025. Covered with this audit will be that the DME date, assessment dates and prescreen dates are all in compliance.
The Administrator will monitor all new residents charts the day after their move in to check that all paperwork, ie DME, Pre-Screen and Rasps are completed and in compliance per the regulations.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented ([redacted] - 09/25/2025)

227g -Support Plan Signatures

18. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted] However, the resident or the assessor did not sign the support plan.

Resident[redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Repeated Violation.[redacted]

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Audit started by Administrator on 8/1/2025 of all resident assessments to ensure that all needs of the residents are being captured. This audit will be completed on all assessments by 9/1/2025. Covered with this audit will be that the DME date, assessment dates and prescreen dates are all in compliance as well as assessors signatures and resident signatures are in place. Audit will also ensure that no correction fluid was used on any of the residents documents.
The Administrator will monitor all new residents charts the day after their move in to check that all paperwork, ie DME, Pre-Screen and Rasps are completed and in compliance per the regulations, and will confirm at that time that no correction fluid was used on any of the documents.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented ([redacted] 09/25/2025)

236 - Staff Training

19. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had zero hours of training in dementia care during the 2024 training year.

236 - Staff Training *(continued)*

Plan of Correction ***Accept (- 09/04/2025)***

Staff member D is currently inactive/on leave due to a work comp case.
A schedule of training was implemented by Business Office Director on 7/18/2025 to ensure all associates who work in Secure Dementia Care Unit have completed 6 hours of dementia care training in addition to 12 hours of annual training prior to end of year 2025.
Business Office Director to continue to audit future training monthly beginning in July 1,2025 through September 1,2025 to verify monthly training completion. Upon completion of the audit, the BOD will ensure that all associates have the proper dementia care training additional 6 hours by providing a dementia care training quarterly to all new associates that began their employment that month.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented - 09/25/2025)

251b - Record Entries Legible

20. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident's assessment covering the previous date and date of was handwritten.

Plan of Correction ***Accept - 09/04/2025)***

In-service was completed by Executive Director for DOW and all staff nurses to ensure that moving forward correction fluid will not be used to make a correction on any documents pertaining to the residents. In-service educates this staff that if an error occurs they are to put a line through and initial.
Audit started by Administrator on 8/1/2025 of all resident assessments to ensure that all needs of the residents are being captured. This audit will be completed on all assessments by 9/1/2025. Covered with this audit will be that the DME date, assessment dates and prescreen dates are all in compliance as well as assessors signatures and resident signatures are in place. Audit will also ensure that no correction fluid was used on any of the residents documents.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented (09/25/2025)

251c - Standardized Forms

21. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident s DME, date , was not completed on the Department's current standardized form.

251c Standardized Forms *(continued)*

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

The Director of Wellness will immediately screen every in coming DME to ensure that it is on the current DME form per the Department. If an incorrect form is sent, DOW is to return the form and ask respectfully for the correct DME to be utilized and returned for compliance. This will be an on going process to ensure compliance for all new residents moving into the community.

Audit started by Administrator on 8/1/2025 of all resident assessments to ensure that all needs of the residents are being captured. This audit will be completed on all assessments by 10/1/2025. Covered with this audit will be that the DME date, assessment dates and prescreen dates are all in compliance as well as assessors signatures and resident signatures are in place. Audit will also ensure that no correction fluid was used on any of the residents documents. Audit will also confirm that proper documents are being used for all assessments and medical evaluation forms.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Implemented [redacted] - 09/25/2025)