pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC**
LEGAL ENTITY

To operate **SPRING MILL SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **98**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 22**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 5,** **2025** until **May 5,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146321**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 5, 2025

[redacted]
KAPG Phoenixville Senior Housing OPCO, LLC
[redacted]

RE: Spring Mill Senior Living
3000 Balfour Circle
Phoenixville, Pennsylvania 19460
License #: 146321

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) licensing inspection March 17 and 18, 2025, June 10, 2025, June 16, 2025, and August 28, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 146320 dated June 2, 2025 to June 2, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from NOVEMBER 5, 2025 to MAY 5, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

[redacted]

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
17	III	88	$3	$264	15 calendar days from mailing date of this letter
42c	II	88	$5	$440	5 calendar days from mailing date of this letter
81b	II	88	$5	$440	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *06/02/2025*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

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

Administrator

Name: [redacted]

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *I-2* **Date**: *12/02/2016* **Issued By**: *East Pikeland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *101* **Waking Staff**: *76*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/18/2025*

Inspection Dates and Department Representative

03/17/2025 - On-Site: [redacted]

03/18/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *81*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *14*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *81*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *20*

Have Physical Disability: *0*

Inspections / Reviews

03/17/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/11/2025*

04/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/23/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/05/2025*

05/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/23/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/23/2025*

09/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/23/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 3/17/2025 the home's current violation report, dated [redacted] 2024, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *POC dated [redacted] 024 was not filed in the DHS binder located at the concierge desk on 3/17/2025.*
- *Executive Director filed POC dated 8/26/2024 in the DHS binder located at the concierge desk on 3/18/2025.*
- *Executive Director will check DHS binder quarterly to ensure the current license and the current license inspection summary issued by DHS is filed in the DHS binder located at the concierge desk.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 07/01/2025)

17 - Record Confidentiality

2. 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 3/17/2025, at 1:57 PM, memory care resident assignment sheets including resident toileting logs were unlocked, unattended, and accessible on a table in the memory care unit activities room.

Repeat violation: 8/26/2024, 1/29/2024 et al

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Assignment sheets were left by staff on the table in the activities room on the memory care unit on 3/17/2025 at 1:57pm.*
- *Director of Memory Care removed the resident assignment sheet from the activities table on 3/17/2025 at 1:57pm and discussed confidentiality with the staff on duty.*
- *Director of Memory Care will re-educate all staff in memory care resident records are to be kept confidential and requiring memory care staff to keep resident assignment sheets in the resident assignment binder and not removing them by 4/30/2025.*
- *Director of Memory Care/Designee will monitor the memory care unit several times daily to ensure assignment sheets are kept in resident assignment binder.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented [redacted] - 07/01/2025)

18 - [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

25b - Contract Signatures

4. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/2025, for resident 1 was not signed by the resident and there was no indication the resident was given the opportunity to sign.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident home-contract dated [redacted]/2025 was not signed by Resident #1.*
- *Resident home-contract dated [redacted]/2025 was signed by Resident #1 [redacted]*
- *Resident #1 was unable to sign the resident-home contract on [redacted]/2025 due to a fractured humerus.*
- *Executive Director attempted to have Resident #1 sign the resident-home contract on [redacted]/2025 and [redacted]/2025 and Resident #1 was unable to do so*
- *Executive Director documented on Resident #1 resident-home contract 2 attempts to sign and Resident #1 was unable to sign on [redacted]9/2025 and [redacted]2025.*
- *Executive Director will audit current resident-home contracts by [redacted]/2025 to ensure all residents have*

25b - Contract Signatures (continued)

signed the resident-home contract.

- *Executive Director will review all new move in resident-home contracts at move in to ensure all signatures are obtained or documented.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented [redacted] 07/01/2025)

26a - Quality Management Plan

5. Requirements

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

Description of Violation

The home's policy/plan for Quality Management is to hold meetings quarterly. The home only conducted two quality management meetings since 1/1/2024. Meetings were held 1/3/2024 and 1/17/2025.

Plan of Correction ***Accept [redacted] - 05/05/2025)***

- *Quality management meetings were held 1/3/2024 and 1/17/2025.*
- *Previous quality management policy was to hold meetings quarterly.*
- *Quality management policy was changed effective immediately 7/1/2024 to hold meetings annually.*
- *Executive Director held quality management meeting on 1/17/2025 which consisted of data collected from 7/2024 to 12/2024, and going forward quality management meetings will be held annually.*
- *Executive Director will hold quality management meetings annually per policy.*

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented [redacted] - 07/01/2025)

42s - Privacy

6. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 3/17/2025 multiple cameras were found throughout the home. There were cameras hanging from the ceiling facing into common areas and down resident halls, cameras facing towards the exit door without proper signage indicating that recording or monitoring was occurring, and small non-commercial cameras faced towards resident rooms in the Secure Dementia Care Unit (SDCU and in the second-floor library. The home indicated that the cameras were placed in various locations as a deterrent for poor behaviors suspected of staff. However at the time of inspection, the cameras were plugged in and appeared to be operating, and the home could not provide proof or a policy showing that these cameras were inoperable and not recording. REPEAT VIOLATION: 1/29/24 et al.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

42s - Privacy (continued)

- *Non-commercial cameras located in the Secured Dementia Care Unit and the second-floor library were remove on 3/18/2025 by the Executive Director.*
- *Security video surveillance policy was available on 3/17/2025 and located in the community policy and procedure manual.*
- *Signage stating that there is 24-hour security video surveillance was posted all exit areas except the main entrance.*
- *Director of Maintenance posted signage at the main entrance stating that there is 24-hour security video surveillance occurring at the main entrance exit on 4/16/2025*
- *Director of Maintenance/Designee will monitor for signage on the daily walk through of the community.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

54a - Direct Care Staff

7. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person B does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Staff person B was hired [redacted]024.*
- *Upon hire Staff person B, presented a high school diploma certificate and the diploma was filed in Staff person B employee file.*
- *DHS inspector googled the high school in which the diploma was issued and found it not to be authorized by the Department of Education.*
- *Staff person B was terminated on [redacted]2025 due to diploma not authorized by the Department of Education.*
- *Staff person B was not aware that the diploma was not authorized by the Department of Education.*
- *Business Office Manager will audit all staff files by 4/30/2025 and check that staff diplomas are issued from a school that is authorized by the Department of Education.*
- *Upon hire Business Office Manager will check all new hire diplomas to ensure they are issued from a school that is authorized by the Department of Education.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Not Implemented ([redacted] - 09/09/2025)

65f - Training Topics

9. 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 D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , and care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2/1/2024-1/31/2025.

Repeat violation: 1/29/2024 et al

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Staff person D did not receive annual training during the training year 2/1/2024-1/31/2025.*
- *Staff person D only worked at the community as needed.*
- *Staff person D last day worked at the community was [redacted]2024 and was [redacted] on [redacted]/2025.*
- *Executive Director will re-educated Business Office Manager on staff completion of annual training topics by 4/22/2025*
- *Business Office Manager will audit all staff files to ensure all staff have completed annual training for training year 2/1/2024-1/31/2025 by 4/30/2025.*
- *Staff that did not complete annual training for training year 2/1/2024-1/31/2025 will not be permitted to work until completed.*
- *Business Office Manager will monitor staff training monthly to ensure that all staff are completing annual training.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented [redacted] - 09/08/2025)

65g - Annual Training Content

10. 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:

65g - Annual Training Content *(continued)*

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 D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable during training year 2/1/2024 to 1/31/2025.

Repeat violation: 6/11/2024, 1/29/2024 et al

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Staff person D did not receive annual fire training during the training year 2/1/2024-1/31/2025.*
- *Staff person D only worked at the community as needed.*
- *Staff person D last day worked at the community was [redacted]/2024 and was [redacted] on [redacted] 2025.*
- *Executive Director will re-educated Business Office Manager on staff completion of annual training topics including fire training by 4/22/2025.*
- *Business Office Manager will audit all staff files to ensure all staff have completed annual fire training for training year 2/1/2024-1/31/2025 by 4/30/2025.*
- *Staff that did not complete annual training for training year 2/1/2024-1/31/2025 will not be permitted to work until completed.*
- *Business Office Manager will monitor staff training monthly to ensure that all staff are completing annual training.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented [redacted] - 07/01/2025)

81b - Resident Personal Equipment

11. 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

On [redacted] 2025 resident 2 had an inverted U-shaped bedside mobility device that was slid between [redacted] mattress and box spring. This device was not attached to the bed at all and pulled out entirely with little force. This device had no cover and had an opening measuring 10 inches by 12 inches above the mattress. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe

81b - Resident Personal Equipment (continued)

gripping and use of the device for its intended purpose must be in place.

Repeat violation: 1/29/2024 et al

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #2 had an inverted U-shaped bedside mobility device placed on bed by family.*
- *At the time of the inspection on 3/18/2025 the Director of Maintenance removed the U-shaped bedside mobility device from the bed.*
- *Director of Maintenance explained to Resident #2 the need for the bedside mobility device to be removed and the safety concerns on 3/18/2025.*
- *On 3/24/2025 Director of Maintenance educated Resident #2 family the safety concerns of the bedside mobility device that had been on the bed.*
- *On 3/24/2025 Director of Maintenance emailed Resident #2 family the approved bedside mobility device.*
- *Resident #2 family purchased the approved bedside mobility device and delivered to the community on 3/27/2025*
- *Director of Maintenance assembled and installed the approved bedside mobility device to Resident #2 bed on 3/28/2025*
- *Director of Health and Wellness/Designee will re-educate all nursing, housekeeping and maintenance staff on the FDA guidelines for approved bedside mobility devices by 4/30/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit all residents to ensure any resident with bedside mobility devices are approved bedside mobility device and are covered, clean and in good repair by 4/30/2025.*
- *Staff assignments were updated on 3/19/2025 include to check for approved bedside mobility devices, and coverings for residents that utilize them.*
- *Director of Health and Wellness/Designee and/or Med tech supervisor will weekly monitor enabler bars are covered.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented ([redacted] - 07/01/2025)

82c - Locking Poisonous Materials

12. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Multiple ECOLAB products including: Dual Action Floor Cleaner, ZephAir Clean White Cotton Tough Odor Remover, and Rapid Multi Surface Disinfectant cleaner, all with a manufacturer's label indicating, "hazards to humans and domestic animals" and "Call poison control center or doctor for treatment advice", were unlocked, unattended, and accessible to residents in the SDCU janitor's closet. Not all the residents of the home, including residents of the SDCU, have been assessed as capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Janitor closet door was unlocked and unattended on 3/17/2025.*
- *On 3/17/2025 housekeeping was on the unit cleaning resident apartments.*
- *Housekeeping entered the janitor closet to obtain chemicals to clean resident apartments, and upon exiting did not ensure the door was shut and locked.*
- *Director of Maintenance replaced lock on janitor closet door on 3/18/2025 to a lock that automatically locks.*
- *Director of Maintenance will re-educate all housekeeping staff on keeping all poisonous materials locked and inaccessible to residents by 4/30/2025*
- *Director of Maintenance/Designee will check janitor closets daily to ensure all are closed and locked.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented ([redacted] - 07/01/2025)

85a - Sanitary Conditions

13. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/18/2025 at 10:34 AM, resident 3's room had a strong odor of urine. The toilet in the bathroom had not been flushed and a puddle of urine was observed on the floor in front of the toilet.

On 3/18/25 at 11:13 AM a drawer in the kitchenette on the 1st floor was filled with dried up brown substance that appeared to be old coffee, coffee lids with dried coffee splashes, empty and torn up sugar packets, and other debris.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #3 is independent, alert and oriented to person, place and time.*
- *On 3/18/2025 at 10:34am Resident #3 was present in apartment and was getting ready for the day when DHS inspector and Director of Maintenance entered the apartment.*
- *Resident #3 had just been in the bathroom and used the toilet on 3/18/2025 at 10:34am.*
- *Director of Maintenance notified housekeeping immediately to clean Resident #3 bathroom.*
- *Ongoing nursing notes on Resident #3 state poor hygiene and apartment cleanliness have been an ongoing concern and have been discussed with Resident #3 and resident #3 family.*
- *Executive Director updated Resident #3 RASP noting poor hygiene and apartment cleanliness issues, and to monitor Resident #3 apartment frequently throughout the day and report any refusals to Director of Health and Wellness.*

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- *On 3/18/2025 coffee and trash were in a drawer in the kitchenette area located on the 1st floor.*
- *Director of Maintenance immediately removed the trash and cleaned the coffee on 3/18/2025.*
- *Director of Maintenance on 3/20/2025 added checking the drawers in the kitchenette area located on the 1st floor to the housekeeping daily checklist.*
- *Director of Culinary educated the dining staff on 3/20/2025 to check daily for spills and trash in the drawers*

85a - Sanitary Conditions (continued)

in the kitchenette area located on the 1st floor when refilling the coffee urns.

- *Director of Maintenance/Designee and Director of Culinary/Designee will monitor drawers daily to ensure sanitary.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

85e - Trash Outside Home

14. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 3/17/25, The facility's main dumpster was half full of trash and it was missing the covers/lids, which appeared to have been broken off the dumpster. Outside the dumpsters, there was a large amount of debris and more trash scattered on the ground and piled up next to the dumpster.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Community dumpster lid was broken off and missing from the dumpster on 3/17/2025.*
- *Director of Maintenance contacted the community's contracted trash company on 3/17/2025 to notify of the broken dumpster lid.*
- *Community's contracted trash company initiated a work order on 3/17/2025 and stated the dumpster lids would be repaired, or they would replace the dumpster within the next 2 weeks.*
- *Director of Maintenance on 3/17/2025 removed any trash and debris that was scattered on the ground next to the dumpster.*
- *Community's contracted trash company replaced the dumpster on 3/21/2025, dumpster lids are intact and in good repair.*
- *Director of Maintenance will re-educate dining and housekeeping staff the importance of keeping the dumpster lids shut and the dumpster area clean to prevent insects and rodents by 4/30/2025.*
- *Director of Maintenance/Designee will monitor area around the dumpster and the dumpster lids weekly and immediately contact the community's contracted trash company if the dumpster lid is missing or broken.*
- *Executive Director will monitor compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented [redacted] - 07/01/2025)

91 - Telephone Numbers

15. 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.

91 - Telephone Numbers *(continued)*

Description of Violation

There are no emergency telephone numbers to include the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline on or by the telephone in in Resident 2's room.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Emergency telephone numbers were not located on or by telephone in Resident # 2 apartment.*
- *Director of Maintenance will post emergency numbers in all resident apartments that include the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint line by 4/25/2025.*
- *Director of Maintenance will re-educate housekeeping staff to check for emergency numbers in resident apartments on their weekly apartment cleaning day by 4/22/2025.*
- *Director of Maintenance/Designee will monitor resident's apartments monthly to ensure emergency phone numbers are in place in each resident apartment.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/25/2025*

Implemented [redacted] - 09/09/2025)

95 - Furniture and Equipment

16. Requirements

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

Description of Violation

On 3/17/25, one of the home's boilers was leaking, creating a puddle of water on the concrete floor below it.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *On 3/17/2025 water was found on the floor below one of the boilers.*
- *Director of Maintenance contacted plumbing company on 3/19/2025 to come out to evaluate the boiler.*
- *Plumbing company evaluated the boiler and needed to order parts.*
- *On 4/8/2025 the Maintenance Director was notified by plumbing company that the part was in to repair the boiler.*
- *Plumbing company repaired the boiler on 4/15/2025.*
- *Director of Maintenance/Designee will monitor boilers and other community equipment on daily walk through of the community and contact contracted company immediately if an issue is observed.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

96a - First Aid Kit

17. Requirements

2600.

101j3 - Bed/Linens/Pillows/Blankets

19. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 3/18/2025 at 10:34 AM resident 3's bed sheets had a large brown stain.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #3 is independent, alert and oriented to person, place and time.*
- *On 3/18/2025 at 10:34am Resident #3 was present in apartment and was getting ready for the day when DHS inspector and Director of Maintenance entered the apartment.*
- *On 3/18/2025 at 10:34am it was noted by DHS inspector that Resident #3 had large brown stain on bed sheets.*
- *Director of Health and Wellness was immediately notified about the dirty linens on 3/18/2025.*
- *Dirty linens were removed, and clean linens were placed by care staff on Resident #3 bed on 3/18/2025.*
- *Ongoing nursing notes on Resident #3 state poor hygiene and apartment cleanliness have been an ongoing concern and Resident #3 refuses assistance from care staff have been discussed with Resident #3 and Resident #3 family.*
- *Executive Director updated Resident #3 RASP on 3/22/2025 noting poor hygiene and apartment cleanliness issues, and to monitor Resident #3 apartment frequently throughout the day and report any refusals of care or hygiene concerns to Director of Health and Wellness/Assistant Director of Health and Wellness.*
- *Resident #3 assignment sheet has been updated to check on Resident #3 frequently throughout the day and*

101j3 - Bed/Linens/Pillows/Blankets (continued)

report any refusals of care or hygiene concerns to Director of Health and Wellness/Assistant Director of Health and Wellness on 3/22/2025 by Assistant Director of Health and Wellness.

- *Executive Director discussed hygiene concerns with Resident #3 on 3/22/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will schedule monthly care meetings with Resident #3 family if refusals of care or poor hygiene continue after conversation with Resident #3 on 3/22/2025.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

101j7 - Lighting/Operable Lamp

20. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 3/18/25, Resident 4 did not have access to a source of light that can be turned on/off at bedside.

On 3/18/25, Resident 5 did not have access to a source of light that can be turned on/off at bedside. The bed side table and lamp were too far from the bed to be able to reach while seated on the bed.

On 3/18/25, Resident 6 did not have access to a source of light that can be turned on/off at bedside. The resident's bed side lamp was inoperable.

Repeat violation: 1/29/2024 et al

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #4 does not have a light source located at bedside.*
- *Resident #5 light source located too far away from bed.*
- *Resident #6 light source located at bedside was inoperable.*
- *Director of Maintenance moved lighting source closer to Resident #4 and Resident #5 bed and for Resident #6 replaced light bulb in lighting source on 3/22/2025.*
- *Director of Maintenance will audit apartments in PC and MC by 4/25/2025 to ensure all residents have an operable lamp or other source of lighting that can be turned on at bedside.*
- *Director of Maintenance will provide if a resident does not have an operable lamp or source of lighting that can be turned on at bedside by 4/25/2025.*
- *Director of Maintenance will re-educate housekeeping staff on every resident is to have an operable lamp or other source of lighting that can be turned on at bedside, and housekeeping staff need to check this weekly when cleaning resident apartments. by 4/22/2025.*

101j7 - Lighting/Operable Lamp (continued)

- *Director of Maintenance/Designee will monitor resident apartments monthly by rotating floors 1 week throughout the month to ensure lights are in place and are operable.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/25/2025*

Not Implemented ([redacted] - 09/09/2025)

101o - Walls, Floors, Ceilings

21. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 3/18/25, the carpet in Resident 3's bedroom had a large brown stain in the living area.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #3 is independent, alert and oriented to person, place and time.*
- *On 3/18/2025 at 10:34am Resident #3 was present in apartment and was getting ready for the day when DHS inspector and Director of Maintenance entered the apartment.*
- *Resident #3 has a stained area located on carpet in apartment.*
- *Director of Maintenance/Housekeeping cleans Resident #3 carpet several times a week.*
- *Ongoing nursing notes on Resident #3 state poor hygiene and apartment cleanliness have been an ongoing concern and have been discussed with Resident #3 and resident #3 family.*
- *Executive Director updated Resident #3 RASP noting poor hygiene and apartment cleanliness issues, and to monitor Resident #3 apartment frequently throughout the day and report any refusals to Director of Health and Wellness.*
- *Resident #3 apartment was evaluated by contracted flooring company and measured on 4/10/2025.*
- *Resident #3 apartment will have flooring removed and replaced by 4/30/2025.*
- *Executive Director discussed hygiene concerns with Resident #3 on 3/22/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will schedule monthly care meetings with Resident #3 family if refusals of care or poor hygiene continue after conversation with Resident #3 on 3/22/2025.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented [redacted] - 09/09/2025)

107b - Emergency Procedures

24. Requirements

107b - Emergency Procedures *(continued)*

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Executive Director updated the community's Emergency Preparedness Plan to include the location of the emergency binder with the resident's designated person and contact information on 3/24/2025.*
- *Executive Director re-educated Concierge on the location of the resident emergency binder and keeping it updated on 4/1/2025.*
- *Concierge will keep the emergency binder updated with new move ins, move outs and designated person or contact information changes.*
- *Executive Director will monitor emergency binder monthly to ensure it is updated.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

123b - Emergency Procedures Posted

25. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 3/17/25, the home's emergency procedures are not posted in a conspicuous and public place in the home. They were located in a locked cabinet in the front desk area.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Emergency procedure binder was located in an unlocked cabinet behind the concierge desk on 3/17/2025.*
- *Emergency procedure binder was placed at the concierge desk in a public conspicuous place on 3/19/2025 by the Executive Director.*
- *Executive Director will re-educate all concierge staff that emergency binder is not to be removed from the current location by 4/25/2025.*
- *Executive Director/Designee will daily monitor the emergency binder is located in a public conspicuous area.*
- *Executive Director will monitor for compliance.*

123b - Emergency Procedures Posted *(continued)*

Licensee's Proposed Overall Completion Date: *04/25/2025*

Implemented [redacted] - 09/09/2025)

132d - Evacuation

27. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 2/17/2025 at 11:36 PM, all residents did not evacuate to a public thoroughfare or a fire safe area within the homes designated safe evacuation time of 15 minutes. During this drill the evacuation time was 22 minutes and 26 seconds.

Plan of Correction ***Accept [redacted] - 05/05/2025)***

- *On 3/17/2025 fire drill logs were given to DHS inspector by Executive Director as requested.*
- *A fire drill was conducted at community on 2/17/2025 at 11:36pm by a contracted fire safety expert.*
- *The community did not pass the fire drill on 2/17/2025 at 11:36pm due to resident evacuation time was not within the period of time specified in writing by the contracted fire safety expert.*
- *Director of Maintenance met with the staff that was present during the time of the fire drill on 2/17/2025 to discuss the reason the fire drill failed. Staff stated that due to the time residents were reluctant to get out of bed and evacuate their apartments.*
- *On 2/26/2025 at 12:09am a fire drill was conducted at the community by a contracted fire safety expert.*
- *The community passed the fire drill on 2/26/2025 at 12:09am, residents evacuated within the period of time specified in writing by the contracted fire safety expert.*
- *Fire drill log presented to the DHS inspector on 3/17/2025 by the Executive Director included the fire drill on 2/26/2025.*
- *On 3/18/2025 DHS inspector questioned the community fire drill log, and the failed fire drill on 2/17/2025 was mentioned during the questioning.*
- *Director of Maintenance will re-educate all staff on evacuation process and time frame for fire drill by 5/16/2025.*
- *Director of Maintenance will re-educate residents during resident council meeting on 5/1/2025 on evacuation process, need to evacuate apartments no matter the time, designated meeting place in each fire zone and the time frame given by the Fire Safe expert..*
- *Director of Maintenance will perform a educational fire drill by 5/16/2025 to educate staff and residents on evacuation procedure, designated meeting place in each fire zone and the time frame given by the Fire Safe expert.*
- *Contracted fire safe expert will conduct fire drills monthly rotating shifts per contract with community.*
- *Director of Maintenance will maintain fire drill documentation monthly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/16/2025*

132d - Evacuation *(continued)*

Not Implemented [redacted] - 09/09/2025)

132h - Designated Meeting Place

28. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drills on 2/26/2025 at 12:09 AM, 1/8/2025 at 9:32 PM, and 12/7/2024 at 3:33 PM, residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. According to resident council meeting minutes and interviews with staff persons and residents, residents are being told to move to their doorways during fire drills, if they do not see a staff member they are not in danger, and when the alarm stops they may return to their rooms. Residents stated that during some drills they did not see a staff person at any time.

Plan of Correction ***Accept [redacted] - 05/05/2025)***

- *Fire drills at the community on 2/26/2025 at 12:09am, 1/8/2025 at 9:32pm and 12/7/2024 at 3:33pm were conducted by a fire safety expert contracted by the community.*
- *Per the documentation noted on the paperwork provided by the fire safety expert states residents evacuated away from the fire into designated fire safe zones on 2/26/2025, 1/8/2025 and 12/7/2024.*
- *Director of Maintenance will re-educate all staff on evacuation process, designated meeting area in fire safe zones and time frame for fire drill by 5/16/2025.*
- *Director of Maintenance will re-educate residents during resident council meeting on 5/1/2025 on evacuation process, need to evacuate apartments no matter the time, designated meeting place in each fire zone and the time frame given by the Fire Safe expert..*
- *Director of Maintenance will perform a educational fire drill by 5/16/2025 to educate staff and residents on evacuation procedure, designated meeting place in each fire zone and the time frame given by the Fire Safe expert.*
- *Contracted fire safe expert will conduct fire drills monthly rotating shifts per contract with community.*
- *Director of Maintenance will maintain fire drill documentation monthly.*
- *Executive Director will monitor for compliance.*

- *Director of Maintenance discusses fire drill evacuation with residents at resident monthly council meetings.*
- *Director of Maintenance discusses fire safe zones and moving away from the fire into a fire safe zone, if the resident apartment is located in the fire safe zone away from the fire they need to come out of their apartment and wait in the fire safe zone until they get notification from staff it is ok to return to their apartment.*
- *Per the documentation noted on the paperwork provided by the fire safety expert states residents evacuated away from the fire into designated fire safe zones on 2/26/2025, 1/8/2025 and 12/7/2024.*
- *Director of Maintenance will educate residents each month on how and where to evacuate during fire drills.*
- *Director of Maintenance will maintain fire drill documentation monthly.*

132h - Designated Meeting Place (continued)

Executive Director will monitor for compliance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented [redacted] - 07/01/2025)

141a - Medical Evaluation

29. 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.

Description of Violation

Resident 7 was admitted [redacted] 2025. Resident 7's medical evaluation was completed on [redacted] /2024. The medical evaluation was not completed within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident # 7 moved into the community [redacted] /2025.*
- *Resident #7 transferred to the physician that comes to the community and was seen by the physician on [redacted] /2025.*
- *On [redacted] /2025 Resident #7 was admitted to the hospital and returned to the community on [redacted] /2025.*
- *Resident #7 was scheduled to see the physician that comes to the community on 2/7/2025.*
- *On [redacted] 2025 Resident #7 was admitted to the hospital and returned to the community on [redacted] /2025.*
- *Resident #7 was scheduled to the physician that comes to the community on [redacted] /2025 and a new DME was obtained at that time but was not located in Resident #7 chart at the time of inspection on 3/18/2025.*
- *Executive Director will re-educate Director of Health and Wellness/Assistant Director of Health and Wellness on obtaining medical evaluation within 60 days prior or 30 days after the resident moves into the community by 4/25/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit resident medical evaluation to ensure compliance by 5/9/2025.*
- *Executive Director will review resident evaluations at move in to ensure compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 09/09/2025)

141b1 - Annual Medical Evaluation

30. 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 [redacted] /2024. The resident's previous medical evaluation was completed on [redacted] /2023.

141b1 - Annual Medical Evaluation (continued)

Repeat violation: 6/11/24, 1/29/2024 et al

Plan of Correction ***Directed [redacted] 05/05/2025)***

****Disputing****

- *Per previous POC dated [redacted] 2024, all DME were audited and completed.*
- *MC audited completed 6/7/2024.*
- *PC audited completed 7/31/2024.*
- *Residents found with late DME will have a med evaluation scheduled with their provider and a DME completed by 8/30/2024.*
- *Resident #3 DME was completed by [redacted] /2024*
- *Resident #8 DME was completed by [redacted] /2024*
- *It is my understanding that if we were cited and it was corrected, we cannot be cited for the same thing if it was prior to the corrected violation. Please see attached documentation from POC [redacted] /2024*

Proposed Overall Completion Date: 05/02/2025

Directed Plan of Correction:

The administrator or designee shall conducted an audit of all current resident DME's within 14 calendar days of the receipt of this plan of correction. DME dates and due dates shall be documented on a tickler file that shall be reviewed monthly for the next 6 months- by at least the 15th of each month. Any resident who has a DME within the next month shall have an appointment scheduled to have the medical evaluation completed timely.
A quarterly review of all current resident DME's shall be conducted to ensure the tickler file and DME Dates align and are compliant with annual due dates.
Documentation of initial audits, monthly reviews and quarterly audits shall be kept and made available to the Department upon request.

Directed Completion Date: *05/02/2025*

Implemented [redacted] - 09/09/2025)

162c - Menus Posted

31. 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 3/17/2025, which is third week of March 2025, the home's menu for "Week 2" with no indication of specific dates was posted. The menu for the next week or "Week 3"was also not posted.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *On 3/17/2025 menus were not posted for current week or 1 week in advance.*
- *Director of Culinary first day of employment at the community was 3/3/2025 and was being trained on*

162c - Menus Posted (continued)

community menu system.

- *Director of Culinary posted current week menu and following week indicating specific dates on 3/19/2025.*
- *Director of Culinary will post menus weekly for the current week and the week following including dates indicating the correct menu.*
- *Executive Director will monitor weekly for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Not Implemented [redacted] 07/01/2025)

171b5 - First Aid Kit

32. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 3/18/25, the first aid kit in the bus used to transport residents does not include a thermometer.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Executive Director placed a thermometer in the first aid kit located in the bus used to transport residents on 3/18/2025.*
- *Executive Director updated policy for first aid kits including location on 3/20/2025.*
- *Executive Director ordered new first aid kits for all locations listed on first aid kit policy on 3/21/2025.*
- *Executive Director replaced first aid kits in all locations listed on first aid kit policy on 3/24/2025.*
- *Executive Director will re-educate Director of Health and Wellness and Assistant Director of Health and Wellness on updated first aid kit policy and audit tool by 3/24/2025.*
- *Director of Health and Wellness/Designee will re-educate all staff on updated first aid kit policy by 4/30/2025.*
- *Director of Health and Wellness will audit first aid kits monthly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Implemented [redacted] - 09/09/2025)

181c - Self-administration Assessment

33. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 3 self-administers medications to include checking blood glucose levels once daily; however, resident 3

181c - Self-administration Assessment (continued)

has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications. Resident 3's most recent medical evaluation that occurred on 6/12/2024 shows that [redacted] cannot self-administer any medication.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #3 medical evaluation dated [redacted] /2024 states they cannot self-administer medications, but Resident #3 is self-administering medications.*
- *Assistant Director of Health and Wellness will assess Resident #3 and all residents that self-administer for the ability to self-administer medications by 4/30/2025.*
- *Assistant Director of Health and Wellness will audit medical evaluations for self-medicating residents to ensure they are accurate with self-medicating capabilities by 4/30/2025.*
- *Assistant Director of Health and Wellness will reach out to resident physician of any resident self-medicating that is assessed and not able to and obtain a medical evaluation stating their capability by 5/9/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will assess residents that self-administer medications annually and obtain a medical evaluation from resident physician stating if they are able to do so.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented [redacted] - 07/01/2025)

181d -Storing Medication

34. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 4 self-administers medications and stores medications in his/her room. On 3/18/2025 at 11:03 AM, there were several unlocked, unattended medications to include over the counter pain relievers and hydrocortisone cream USP 2.5% with prescription label on a table in the resident's living area.

Resident 8 self-administers medications and stores medications in [redacted] room. Resident 8 stores some medications in a lockable kitchen drawer and other medications including fentanyl patch 12 MCG and oxycodone 10MG in a plastic container in [redacted] r bedroom dresser. Resident 8 does not lock his/her room while going to meals or activities in the building.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #4 and Resident #8 self-administer medications and store medication in apartment. Medication was not locked in drawer.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit all resident apartments that self-administer medications, medication orders and medication storage by 5/9/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will educate residents that self-administer medication on proper storage of medications in their apartment by 5/9/2025.*

181d -Storing Medication (continued)

- *Assistant Director of Health and Wellness will monitor resident apartments and medication storage monthly.*
- *Director of Health and Wellness will monitor resident apartments and medication storage quarterly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented (- 07/01/2025)

181f - Record of Medication

35. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 3/18/2025, resident 8's record did not include a current list of medications. The list in the resident's record did not include the following prescribed medications: prednisone 10 mg, Jardiance 10 mg, folic acid 1 mg, lisinopril, Eliquis 5 mg, escitalopram 20 mg, fentanyl patch 12 MCG, and oxycodone 10 mg.

Plan of Correction ***Accept - 05/05/2025)***

- *Resident #8's record did not include all prescribed medications.*
- *Resident #8 self-administers medications and is very independent with doctor appointments and medications.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit medication lists of all residents that self-administer medications by 4/30/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will obtain current medications lists for all residents that self-administer medications if all prescribed medications are not listed on medication list by 5/9/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit medication list and the medications located in residents apartments for residents that self administer medications monthly to verify current med lists and current medications in the resident apartments.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/01/2025*

Not Implemented - 07/01/2025)

182b - Prescription Medication

36. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.

182b - Prescription Medication *(continued)*

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 3/11/2025 at 8:00 PM staff person B administered medications to residents to include the following; omega-3 ethyl esters 1 gm capsule to resident 9. Staff person B is not a staff person who has completed the medication administration training as specified in § 2600.190. Staff person B completed only the paper version of the Department-approved medications administration course on 3/8/2024 which was discontinued 12/31/2023, at which time all initial training was to be completed via the online platform.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *On 3/18/2025 it was noted by DHS inspector that Staff person B only completed the paper version of the Department-approved training on 3/8/2024 which was discontinued 12/31/2023 and did not complete the online training.*
- *Staff person B was immediately removed as med tech for any further scheduled shifts on [redacted]/2025.*
- *Director of Memory Care has passed the Department approved "Train the Trainer" course on 2/12/2025. Director of Memory Care completed an audit for med training paperwork and documentation for staff members that administer medications to residents on 4/11/2025.*
- *All med trained staff are in compliance with med training paperwork and documentation per audit completed by Memory Care Director on 4/11/2025.*
- *Director of Memory Care created a binder on 4/11/2025 to include all paperwork for staff trained to administer medications to residents.*
- *Director of Memory Care will monitor med administration paperwork and keep in compliance.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will monitor med administration paperwork monthly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

183b - Meds and Syringes Locked

37. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/18/2025 at 10:51 AM, deep sea nose spray prescribed for resident 2 was unlocked, unattended, and accessible in the resident's room.

Plan of Correction ***Accept ([redacted]S - 04/30/2025)***

183b - Meds and Syringes Locked (continued)

- *Resident #2 self-administer medications and store medication in apartment. Medication was not locked in drawer.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit all resident apartments that self-administer medications, medication orders and medication storage by 5/9/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will educate residents that self-administer medication on proper storage of medications in their apartment by 5/9/2025.*
- *Assistant Director of Health and Wellness will monitor resident apartments and medication storage monthly.*
- *Director of Health and Wellness will monitor resident apartments and medication storage quarterly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented [redacted] - 07/01/2025)

183d - Prescription Current

38. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 3/18/2025, docusate 100 mg capsule prescribed for resident 10, was in the home's medication cart; however, the medication was discontinued on 3/1/2025.

On 3/18/2025 two blister packs of oxycodone HCL 20 mg tablets and a package of morphine .5ml syringes belonging to resident 11 were in the home's medication cart. Resident 11 passed away on [redacted]/2025.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *On 3/18/2025 discontinued medication for Resident #10 was in the medication cart.*
- *On 3/18/2025 medication for Resident #11 that passed away on [redacted]/2025 was in the medication cart.*
- *Director of Health and Wellness removed the medication for Resident #10 and Resident #11 from the medication cart on 3/18/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit all medication carts by 5/9/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will re-educate all nurses and staff trained to administer medications on only current prescribed medications for residents living at the community are to be kept in the community by 4/30/2025.*
- *Medication carts and resident medications will be audited weekly rotating carts by Assistant Director of Health and Wellness to ensure only current prescribed medications are kept at the community.*
- *Director of Wellness/Designee will monitor medication carts and resident medications monthly during medication change over. .*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented [redacted] - 07/01/2025)

183e - Storing Medications

39. 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

On 3/18/2025 there were 2 half tablets loose in the third drawer of the SDCU medication cart, and 1 loose pill in cart A and one loose pill in cart B.

Resident 10's melatonin 5 mg tablet was in the home's medication cart but expired on 2/28/2025.

Repeat violation: 1/29/2024 et al

Plan of Correction ***Accept ([redacted] - 04/30/2025)***

- *On 3/18/2025 loose medication was observed in the drawer of the medication cart in SDCU and in medication A and B.*
- *On 3/18/2025 expired medication for Resident #10 was in the medication cart.*
- *Director of Health and Wellness removed the expired medication for Resident #10 and the loose pills found in medication carts in SDCU, cart A and cart B medication cart on 3/18/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit all medication carts by 5/9/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will re-educate all nurses and staff trained to administer medications on only current prescribed medications for residents living at the community are to be kept in the community by 4/30/2025.*
- *Medication carts and resident medications will be audited weekly rotating carts by Assistant Director of Health and Wellness to ensure prescribed medications are not expired and there are not any loose pills located in the medication cart drawers.*
- *Director of Wellness will monitor medication carts and resident medications monthly at change over.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented ([redacted] - 07/01/2025)

183f - Discontinued Medications

40. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 3/18/2025 during a medication pass observation, staff person F spilled a resident's medication on the floor. The spilled medication was then given to another staff person to dispose and that staff person threw the medications into trash. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

183f - Discontinued Medications *(continued)*

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Staff person F spilled resident medication during DHS Inspector medication administration observation on 3/18/2025.*
- *Staff person F gave spilled medication to another staff person and the medication was not disposed properly.*
- *Executive Director will re-educate Director of Health and Wellness/Assistant Director of Wellness on destroying medication in a safe manner according to the DEP and Federal and State regulations by 4/30/2025.*
- *Director of Health and Wellness will re-educate all nurses and staff trained to administer medications on destroying medication in a safe manner according to the DEP and Federal and State regulations by 4/30/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will monitor disposal of medications to ensure medications are destroyed in a safe manner according to the DEP and Federal and State regulations.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented[redacted] - 09/09/2025)

185a - Implement Storage Procedures

41. Requirements

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

Description of Violation

The home's medication policy states: "Controlled substances will be stored under double lock in a locked cabinet separate from other medications and with a different key for access". On 3/18/2025 two blister packs of oxycodone HCL 20 mg tablets and a package of morphine .5ml syringes belonging to resident 11 were in the home's medication cart but were stored outside of the locked narcotic box, and therefore were not double locked.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *On 3/18/2025 medications that are controlled substance for Resident #11 were location in the medication cart outside the locked narcotic box.*
- *Resident #11 passed on [redacted] 2025.*
- *Director of Health and Wellness removed the controlled medication from the medication cart on 3/18/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit all medication carts by 5/9/2025*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will re-educate all nurses and staff trained to administer medications on controlled substance storage for residents living at the community are to be kept in the community by 4/30/2025.*
- *Medication carts and resident medications will be audited weekly rotating carts by Assistant Director of Health and Wellness to ensure controlled medications are stored per policy.*
- *Director of Wellness/Designee will monitor medication carts and resident medications monthly during medication change over.*
- *Executive Director will monitor for compliance.*

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented [redacted] - 07/01/2025)

187a - Medication Record

42. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 9 is prescribed blood glucose readings to be taken 3 times daily, and to receive insulin injections based off a sliding scale 3 times daily. The sliding scale is: under 150 = no units, 151-200 = 5 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 14 units, over 350 = 16 units. However, resident's 9's 3/2025 Medication Administration Record (MAR) does not indicate the glucose readings taken on the glucometer and the amount of insulin units administered per the sliding scale.

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #9 MAR does not indicate the glucose readings on the glucometer and the amount of insulin units administered per the sliding scale.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will re-educate nurses and all staff trained to administer insulin on documentation of glucose readings and administration of insulin by 5/9/2025.*
- *Assistant Director of Wellness will audit documentation on residents needing glucose readings and administration of insulin by 4/30/2025*
- *Assistant Director of Health and Wellness will monitor documentation on medication administration record to ensure documentation is in compliance weekly*
- *Director of Health and Wellness will monitor documentation on medication administration record to ensure documentation is in compliance monthly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented [redacted] - 07/01/2025)

187b - Date/Time of Medication Admin.

43. 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 12's is prescribed morphine sulf 100 mg/ 5 ml as every 3 hours needed by mouth. On resident's 12's narcotic log this medication is signed out on 3/9/2025 at 8:00 PM. Resident 12's 3/2025 MAR does not include the initials of the staff person who administered the medication on 3/9/2025 at 8:00 PM.

Plan of Correction ***Accept (MS - 04/30/2025)***

- *Resident #12's MAR does not include the initials of the staff person that administered the medication on 3/9/2025 at 8:00pm.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will re-educate nurses and staff trained to administer medication on documenting at the time the medication is administered by 5/9/2025*
- *Assistant Director of Health and Wellness will monitor documentation of administered medications weekly.*
- *Director of Health and Wellness will monitor documentation monthly.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Not Implemented (MS - 09/09/2025)

190a - Completion Medication Course

44. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person G has not successfully completed the Department-approved medications administration course, because the last recorded annual practicum occurred in [redacted]/2023. Staff person G administered medications to residents to include the following:
On 3/10/2025 at 8:00 AM, olanzapine 2.5 mg tablets to resident 10.

Plan of Correction ***Accept [redacted] 04/30/2025)***

- *On 3/18/2025 it was noted by DHS inspector that Staff person G's last recorded annual practicum occurred [redacted]/2023.*
- *Staff person G was immediately removed as med tech for any further scheduled shifts on [redacted]/2025.*
- *Director of Memory Care has passed the Department approved "Train the Trainer" course on 2/12/2025.*
- *Staff person G completed the Department approved medication administration course on 4/4/2025.*
- *Director of Memory Care completed an audit for med training paperwork and documentation for staff members that administer medications to residents on 4/11/2025.*
- *All med trained staff are in compliance with med training paperwork and documentation per audit completed by Memory Care Director on 4/11/2025.*
- *Director of Memory Care created a binder on 4/11/2025 to include all paperwork for staff trained to administer medications to residents.*
- *Director of Memory Care will monitor med administration paperwork and keep in compliance.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will monitor med administration*

190a - Completion Medication Course (continued)

paperwork monthly.

- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented [redacted] - 09/09/2025)

225c - Additional Assessment

45. 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 8's [redacted]/2024 medical evaluation showed that the resident needed assistance with being offered medication at the prescribed time. Resident 8's assessment was completed on [redacted]/2024 shows that resident 8 is able to self-administer medication with no assistance.

Repeat violation: 8/26/2024; 1/29/2024 et al

Plan of Correction ***Accept [redacted] - 04/30/2025)***

- *Resident #3 assessment dated [redacted] 2024 was not signed by assessor.*
- *Executive Director will re-educate Director of Health and Wellness/Assistant Director of Health and Wellness on signing assessments when completed by [redacted]/2025.*
- *Director of Health and Wellness/Assistant Director of Wellness will audit all resident's assessments for signatures by [redacted]/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will sign assessments when completed.*
- *Executive Director will monitor for compliance.*

- *Resident #8 medical evaluation on [redacted]/2024 stated resident needed assistance with being offered medication at the prescribed time, but assessment on [redacted]/2024 stated Resident #8 is able to self-administer medication.*
- *Director of Health and Wellness/Assistant Director of Wellness will assess Resident #8 for self-administering medications by [redacted]/2025.*
- *Director of Health and Wellness/Assistant Director of Wellness will obtain a new medical evaluation and will complete a new assessment and support plan to reflect resident self-medicating status by 5/16/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will audit medical evaluations, assessments and support plans for residents that self-administer medication to ensure they reflect resident capability by 5/16/2025.*

225c - Additional Assessment (continued)

- *Director of Health and Wellness will monitor medical evals when received and complete assessment appropriately.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented [redacted] - 09/09/2025)

[redacted]

252 - Record Content

48. 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.
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 3's record does not include a photograph of the resident that is no more than 2 years old.

Resident 14's record does not include a photograph of the resident that is no more than 2 years old.

252 - Record Content (continued)

Resident 15's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept [redacted] 04/30/2025)***

- *Resident #3, Resident #14 and Resident #15 photograph in record is more than 2 years old.*
- *Director of Celebrations/Designee will take PC/MC resident photographs by 4/30/2025.*
- *Director of Health and Wellness/Assistant Director of Health and Wellness will add PC/MC photographs into resident record by 5/9/2025.*
- *Executive Director updated community policy on 4/1/2025 resident photographs to include that resident photos will be taken annually.*
- *Director of Activities/Designee will take all resident photos in PC/MC annually in January.*
- *Sales Associate will take pictures of move ins on the day of move in.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 09/09/2025)

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

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *06/02/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

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

Administrator

Name: [redacted]

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Twnshp*

Type: *I-2* **Date**: *12/20/2016* **Issued By**: *East Pikeland Twnshp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *105* **Waking Staff**: *79*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *06/10/2025*

Inspection Dates and Department Representative

06/10/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *86*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *15*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

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

Have Mobility Need: *19* **Have Physical Disability**: *0*

Inspections / Reviews

06/10/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2025*

07/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/22/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/22/2025*

09/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/22/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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 6/10/25 at 9:43am, memory care resident assignment sheets including resident toileting logs were unlocked, unattended, and accessible in the memory care unit activities room. Repeat Violation Date: 8/26/24, 1/29/24 et al.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

- *On 6/10/2025 at the time of DHS inspection, an assignment sheet was located behind in a binder in the memory care activity room.*
- *Memory Care Director immediately removed the assignment sheet on 6/10/2025.*
- *Memory Care resident assignment sheets and toileting logs will be kept in the locked laundry room located on the memory care unit as of 8/8/25 after memory care staff have been re-educated.*
- *Memory Care Director will re-educate all memory care staff on confidentiality and resident records and information may not be accessible to anyone other than the resident, resident's designated person, staff for the purpose of providing services, agents of the Department and the long-term care ombudsman by 7/31/25.*
- *Memory Care Director will re-educate memory care staff members on the location of the resident assignment sheets and toileting logs by 7/31/25.*
- *Memory Care Director/Designee will complete and document a daily walk through in memory care taking note of any assignment sheets or resident records unlocked, unattended and accessible to anyone.*
- *Documentation of daily walk through in Memory Care Unit will be kept in Memory Care Director Office.*
- *Executive Director will monitor compliance monthly by reviewing documentation of daily walk through in Memory Care Unit.*

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

Not Implemented [redacted] - 09/05/2025)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. The certified employee must be available during all hours of operation. withdrawn AD 10/17/25

Staff members A, B and C hold food manager certifications; however, they are not scheduled to work at all dates and times during the week when food is being prepared.

[redacted]

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/25, for resident #1 was not signed by the resident.

The resident-home contract, dated [redacted]25, for resident #2 was not signed by the resident.

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *Resident #1 and Resident #2's contracts were not signed by the resident at the time of move into community's Memory Care Unit.*
- *During the DHS inspection it was noted that Resident #1 and Resident #2's family wrote in their name.*
- *Director of Memory Care will audit all contracts for residents in the Memory Care Unit by 7/25/25, any contracts that were not signed by the resident Memory Care Director will obtain resident signatures and document on the contract.*
- *Executive Director will review all resident contracts at move in to ensure residents, resident's designated person and administrator/designee have signed the contract.*

Licensee's Proposed Overall Completion Date: *07/25/2025*

Not Implemented [redacted] - 09/05/2025)

65g - Annual Training Content

4. Requirements

65g - Annual Training Content *(continued)*

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

Description of Violation

Staff Member D did not complete resident rights training in the 2024 staff training year.
REPEAT VIOLATION: 1/29/24 et al.

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *Staff member D did not complete the resident rights training in the 2024 staff training year.*
- *Staff are assigned annual trainings via training program*
- *Business Office Manager reviewed Staff member D assigned trainings on 6/10/25 and noted they were not assigned resident right training in the 2024 staff training year.*
- *Business Office Manager emailed Director of Clinical Education and Development on 6/11/25 to alert of the issue.*
- *Business Office Manager audited staff assigned trainings on 6/10/25 for any additional non-compliance.*
- *Director of Clinical Education and Development verified community is enrolled in both orientation and annual training plans that include Resident Rights education on 6/11/25.*
- *Business Office Manager will monitor that any staff member that has not completed Resident Right education for 2024 has completed the training by 7/31/25.*
- *Business Office Manager will monitor staff members upon hire and verify they have been assigned all required orientation and annual training.*
- *Business Office Manager will audit every December that annual assigned trainings have been assigned to all staff.*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

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 #3 has a bedside mobility device. The device not securely attached to bed at all and slides out easily from under the mattress creating an entrapment zone. The measurement between the upright rails of the device and the top handle of the device measures 7in x 11in and has no cover.

Resident #4 has a bedside mobility device. The device was securely attached between mechanical frame and mattress but was covered with a loose pillowcase. This is not the proper cover for this device.

Resident #5 has a bedside mobility device. The device not attached to bed frame at all and slides out easily creating an entrapment zone. The measurement between the upright rails of the device and the top handle of the device measures 8 in x 9 in and is not covered.

Repeat Violation Date: 1/29/24 et al.

81b - Resident Personal Equipment (continued)

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *On 6/14/25, the Director of Maintenance completed an inspection of every resident apartment and compiled a list of residents who have a bed enabler bar.*
- *On 6/14/25, the Director of Maintenance verified that all bed enabler bars in resident apartments were in compliance with DHS regulations, ensuring they were properly attached to the bed and covered with an FDA-approved covering.*
- *On 6/16/2025, the Executive Director emailed the families of residents identified as having bed enabler bars. The email outlined DHS regulations regarding bed enabler bars, and informed families that any bars not in compliance would need to be removed and replaced with compliant equipment. A link to the DHS-approved bed enabler bar was provided.*
- *Executive Director purchased DHS-approved bed enabler bars and notified families that if no response was received by 6/20/25, maintenance would proceed with replacing non-compliant bed enabler bars.*
- *Director of Maintenance and Maintenance Assistant removed bed enabler bars from resident beds per family requests and replaced non-compliant bars with DHS-approved models and was completed on 7/11/25.*
- *Executive Director will approve any bed enabler bars for new residents moving into the community to ensure compliance.*
- *Executive Director will educate the Director of Sales and provide information to be shared with prospective families regarding approved bed enabler bars and DHS requirements by 7/31/25.*
- *Executive Director will meet with the in-house therapy group to review approved bed enabler bars by 7/31/25, therapy will only recommend DHS-approved bed enabler bars, educate residents on DHS regulations (including proper attachment and FDA-approved coverings), and notify the Executive Director whenever a bed enabler bar is recommended.*

Licensee's Proposed Overall Completion Date: *07/31/2025*

81b - Resident Personal Equipment *(continued)*

Not Implemented (- 09/05/2025)

82c - Locking Poisonous Materials

6. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 6/10/25 at 9:45am, Peroxide Multi-Surface Cleaner with a manufacturer's label indicating "contact Poison Control if ingested" was found unlocked in a bottom cabinet in the memory care activity area. Not all of the residents of the memory care unit have been assessed as capable to safely recognize and avoid poisonous materials.

Plan of Correction ***Accept 07/25/2025)***

- *On 6/10/25 at the time of DHS inspection a bottle of peroxide multi-surface cleaner was found in an unlocked cabinet in the memory care activity area.*
- *Director of Memory immediately on 6/10/25 removed the bottle of peroxide multi-surface cleaner from the unlocked cabinet and placed it in the locked housekeeping closet.*
- *Director of Memory Care will re-educate Memory Care staff members on keeping poisonous materials locked and inaccessible to residents that reside in the Memory Care Unit, as they have been assessed not capable to safely recognize and avoid poisonous materials by 7/31/25.*
- *Memory Care Director/Designee will complete and document a daily walk through in memory care taking note all poisonous materials are locked and inaccessible to memory care residents.*
- *Documentation of daily walk through in Memory Care Unit by Memory Care Director/Designee will be kept in Memory Care Director Office.*
- *Executive Director will monitor compliance of daily walk through monthly by reviewing documentation of daily walk through in Memory Care Unit.*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented (- 09/05/2025)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 6/10/25 at 1:35pm, the shower chair in Resident#6's room had a pad on it which was stained brown. These stains appeared to be from feces.

Plan of Correction ***Accept - 07/25/2025)***

- *On 6/10/25 at 1:35 PM, a stained pad was observed on a shower chair in Resident #6's bathroom.*
- *Care staff were immediately alerted, and the pad was removed and properly disposed of on the same day (6/10/25).*

85a - Sanitary Conditions (continued)

- *Resident #6 is independent, alert, and oriented.*
- *However, ongoing nurses' notes indicate that poor personal hygiene and apartment cleanliness have been persistent concerns.*
- *These issues have been previously discussed with Resident #6 and Resident #6's family with no resolve.*
- *Resident #6's RASP documentation notes these concerns and directs staff to:*
  - *Monitor Resident #6's apartment frequently throughout the day, and*
  - *Report any refusals related to hygiene or cleanliness interventions*
- *Executive Director will schedule a meeting with Resident #6 and Resident #6's family by 8/1/25 to address the ongoing concerns related to hygiene and apartment cleanliness. During this meeting, a formal plan of care will be developed to effectively manage and support Resident #6's needs in these areas.*
- *Executive Director will discuss with Resident #6 and Resident #6's family that if the ongoing concerns regarding hygiene and apartment cleanliness continue, the community may need to consider issuing a 30-day notice, in accordance with residency agreements and community policies.*

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/05/2025)

85e - Trash Outside Home

8. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/10/25, pallets were found next to the back dock. Broken chairs were found strewn around the dumpster area.

Plan of Correction ***Accept [redacted] 07/25/2025)***

- *On 6/10/25, during a DHS inspection, two chairs were found placed next to the dumpster and pallets were stacked by the back dock area.*
- *The pallets were awaiting scheduled pickup.*
- *The chairs by the dumpster had been placed there by a resident's family without notifying the community.*
- *Director of Maintenance or designee will inspect the dumpster area daily and document findings.*
- *This documentation will be kept at the dock doors exiting the community, near the dumpster area.*
- *All staff members who dispose of trash in the dumpster will:*
  - *Document each time they dispose of trash, verifying that the dumpster lid is closed and the area is clean and free of any objects.*
  - *Immediately report any issues (e.g., open lid, trash or objects in the area) to the Director of Maintenance or their supervisor, who will ensure the issue is addressed promptly.*
- *Director of Maintenance will educate all staff by 7/31/25 that are responsible for disposing of trash on:*
  - *How to properly check the dumpster area,*
  - *Ensuring the lid is closed*
  - *Completing the required documentation*
- *he Executive Director will:*
  - *Review the documentation monthly*

85e - Trash Outside Home (continued)

- *Conduct intermittent inspections of the dumpster and surrounding area to ensure ongoing compliance*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

132h - Designated Meeting Place

10. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Per staff and resident interviews conducted by the Department, residents are not evacuating to a designated meeting place within the fire safe area during fire drills. Residents are standing outside of their apartment doors.

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *On June 11, 2025, the Director of Maintenance contacted the community's fire safety expert to discuss establishing designated meeting areas within fire-safe zones for use during fire drills.*
- *Director of Maintenance will create evacuation route and designated meeting area located in each fire safe zone, educate and distribute to residents by 7/31/25.*
- *The Director of Maintenance will review the evacuation process and designated meeting areas during the monthly Resident Council meetings, ensuring that all procedures are clearly communicated and understood by residents.*
- *The fire safety expert will monitor resident evacuation during each monthly meeting, provide education to staff and residents, and report any concerns to the Director of Maintenance and Executive Director in a monthly fire drill report.*
- *The Director of Maintenance will provide re-education as needed based on these reports to maintain safety and compliance.*
- *Fire drills and evacuation process will be discussed during quality assurance meetings.*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

162c - Menus Posted

11. 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 6/10/25, the home's menu for the week of 6/8/25 through 6/14/25 was posted. However, the menu for 6/15/25 through 6/21/25 was not posted.

162c - Menus Posted *(continued)*

Plan of Correction ***Accept (- 07/25/2025)***

- *On 6/10/25, during the DHS inspection, it was noted that the menu for the upcoming week (6/15/25 through 6/21/25) was not posted.*
- *Menus displayed at that time were for the week of 6/8/25 through 6/14/25.*
- *Director of Culinary had temporarily removed the upcoming week's menu from the display case in order to make final edits and place the associated food order for 6/15/25 through 6/21/25.*
- *The Director of Culinary will no longer remove the menus from the display case when editing or placing food orders, ensuring that menus remain continuously posted and accessible for residents, staff, and visitors at all times.*
- *The Executive Director will conduct weekly checks of the display case to ensure that menus for the current week and upcoming week are properly posted and up to date.*

Licensee's Proposed Overall Completion Date: *07/13/2025*

Not Implemented - 09/05/2025)

181c - Self-administration Assessment

12. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #4 self-administers medications to include Acetaminophen 500mg and Robitussin however, Resident #5 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Resident #6 self-administers medications to include Centrum Vitamins however, Resident #6 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Resident #8 self-administers medications ZzzQuil, however, Resident #8 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Resident #9 self-administers medications to include Albuterol Sulfate, Chest congestion relief 100mg and CVS Allergy Relief however, Resident #9 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept - 07/25/2025)***

- *Resident #8 was assessed by a physician on 25 and is capable of self-administering medications.*

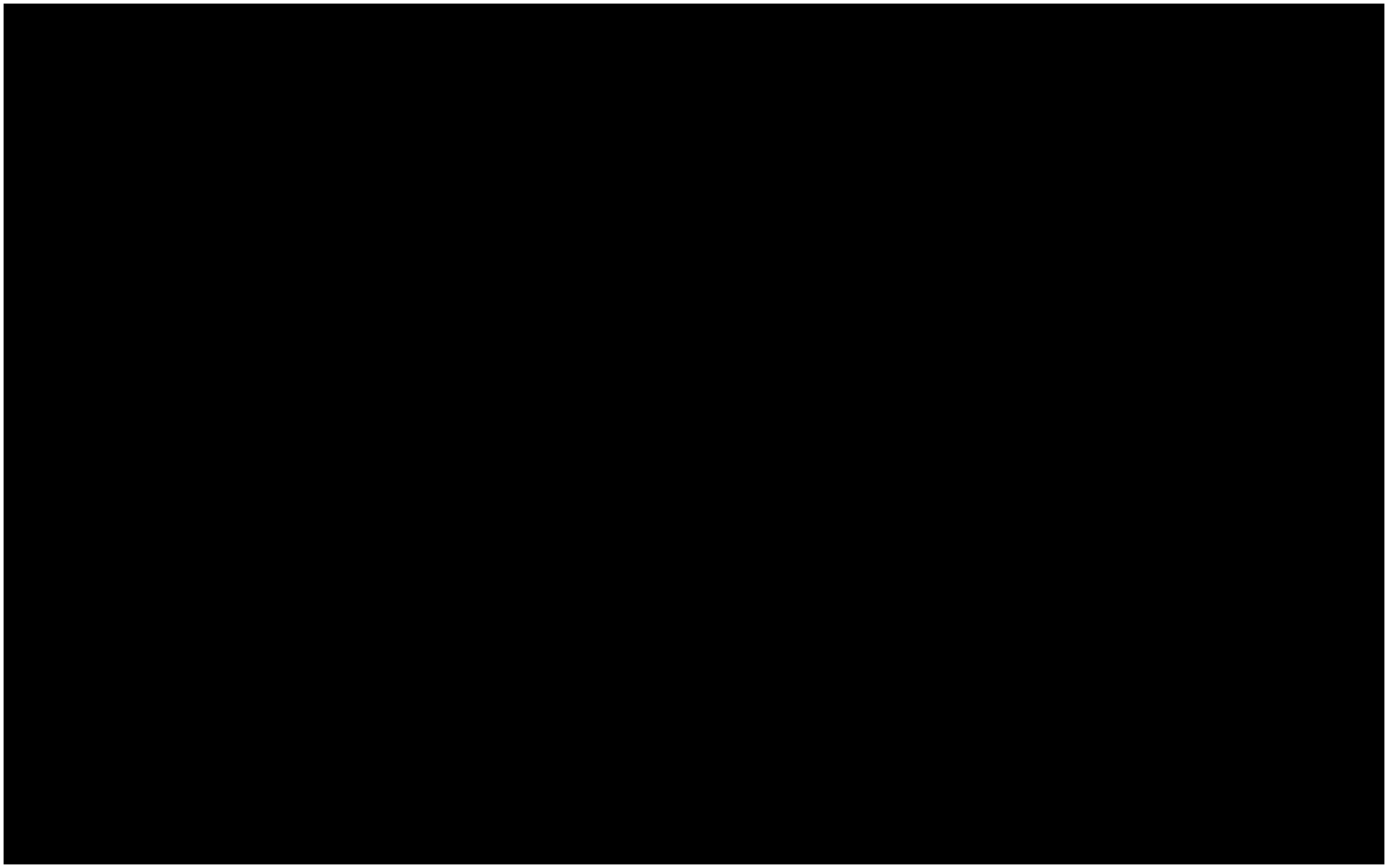
181c - Self-administration Assessment (continued)

- *Executive Director sent an email to all PC resident families educating the families about DHS regulations pertaining to residents that do not have a physician order to self administer medications may not have medications in their apartments, including over the counter medications and that we have to have an order from their physician for all medications on 7/9/25. Residents and families were made aware that Executive Director and Assistant Director of Wellness will be checking resident apartments for any medications, removing the medication from their apartment and obtaining a physician order for the medication, if there is not a current order.*
- *Executive Director and Assistant Director of Health and Wellness will re-assess all residents that actively self administer medication, verify their ability to self administer medication and ensure medications in their apartment match the active physician orders by 7/31/25.*
- *Executive Director and Assistant Director of Health and Wellness will remove medications from resident apartments that are not assessed to have the capability to self administer medications, obtain a new DME and RASP by 8/8/2025.*
- *Assistant Director of Health and Wellness/Designee will assess residents that self administer medications annually or if there is a status change.*
- *Assistant Director of Health and Wellness/Designee will monitor resident apartments quarterly that self administer medications to ensure medications in their apartment matches the medications prescribed by their physician.*
- *Residents that self administer medications will be discussed and reviewed at annual QA meeting.*

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

Not Implemented (- 09/05/2025)

[redacted]



181f - Record of Medication

14. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

Resident #3 is prescribed Levothyroxine 175mg. The resident had 200mg present in their room. Resident #3 also had bottles of valerian and melatonin present in their room which were not on the resident's medication list.

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *Resident #3 was assessed by a physician on [redacted] 2024 and determined capable of self-administering medications.*
- *On 6/19/25, the Executive Director emailed all families of residents who currently self-administer their medications.*
- *The communication provided education on DHS regulations regarding residents who self-administer medications.*
- *Families and residents were informed that the Executive Director and Assistant Director of Health and Wellness will be conducting assessments to evaluate each resident's continued capability to self-administer medications safely.*

181f - Record of Medication (continued)

- *The email also explained that if a resident is assessed as not capable of self-administering medications, the community will:*
  - *Remove the medications from the resident's apartment, and*
  - *Begin administering medications directly to the resident, in accordance with DHS requirements*
- *Executive Director and Assistant Director of Health and Wellness will re-assess Resident #3 by 7/31/25 to:*
  - *Verify their ability to self-administer medications, and*
  - *Ensure that the medications in their apartment match the active physician orders.*
- *On 7/9/25, the Executive Director emailed all Personal Care resident families, educating them that:*
  - *Residents who do not have a physician order to self-administer medications may not keep medications in their apartments, including over-the-counter medications.*
  - *The community must have a physician order on file for all medications.*
- *Residents and families were informed that the Executive Director and Assistant Director of Health and Wellness will be checking resident apartments for medications, removing any medications not covered by a current physician order, and obtaining appropriate orders as needed.*
- *The Assistant Director of Health and Wellness or designee will:*
  - *Assess residents who self-administer medications annually, or sooner if there is a change in condition.*
  - *Monitor resident apartments quarterly to ensure medications present match those prescribed by the resident's physician.*
- *Residents who self-administer medications will be reviewed with the Executive Director during the annual QA (Quality Assurance) meeting.*

Licensee's Proposed Overall Completion Date: *08/15/2025*

Not Implemented [redacted] 09/05/2025)

183b - Meds and Syringes Locked

15. Requirements

2600.

183b - Meds and Syringes Locked *(continued)*

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 6/10/25, a bottle with handwritten label indicating "Acetaminophen 500mg" belonging to Resident #4 was unlocked, unattended and accessible in Resident #4s room. Resident is not assessed as capable of self administering medications.

On 6/10/25, a bottle of ZzzQuil, and a tub of Triamcinolone Acetonide cream belonging to resident #7 was unlocked, unattended and accessible in Resident #7s room. Resident is not assessed as capable of self administering medications.

On 6/10/25, a bottle of Walgreens Pain Reliever, an inhaler of Albuterol Sulfate, and a bottle of OTC Chest Congestion Relief belonging to resident #8 was unlocked, unattended and accessible in Resident #8s room. Resident is not assessed as capable of self administering medications.

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *Resident #8 was assessed by a physician on [redacted]5 and determined capable of self-administering medications.*
- *The Assistant Director of Health and Wellness re-assessed Resident #8 on [redacted]/25, confirming continued capability to self-administer. At that time, education was provided to Resident #8 on the requirement to keep medications locked in their apartment when unattended.*
- *On 7/9/25, the Executive Director emailed all Personal Care resident families, informing them that:*
  - *Residents without a physician's order to self-administer medications may not keep medications in their apartments, including over-the-counter items.*
  - *A physician's order is required for all medications kept in resident apartments.*
  - *Residents and families were made aware that the Executive Director and Assistant Director of Health and Wellness will be checking resident apartments, removing any medications not supported by a current physician order, and obtaining necessary orders.*
- *Executive Director and Assistant Director of Health and Wellness will complete checks of all Personal Care resident apartments for medications by 8/22/25.*
- *The Executive Director and Assistant Director of Health and Wellness will prioritize checking the apartments of residents identified during the DHS inspection on 6/10/25 as having medications in their apartments, to ensure compliance with physician orders and regulatory requirements.*
- *The Assistant Director of Health and Wellness will re-educate all nurses and med techs that if medications are found in a resident's apartment without a physician order for self-administration, the medications must be removed immediately, and an order obtained from the resident's physician by 8/8/25.*
- *The Assistant Director of Health and Wellness or designee will conduct quarterly checks of resident apartments, and the findings will be reviewed and discussed at the Quality Assurance (QA) meeting to ensure continued compliance and resident safety.*

183b - Meds and Syringes Locked (continued)

Licensee's Proposed Overall Completion Date: *08/22/2025*

Not Implemented [redacted] - 09/05/2025)

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted]25, Lokelma 10g powder for resident #9- take 1 packet by mouth daily for two days, ordered on [redacted]/25, was found in the home's medication cart. This medication was discontinued after 4/30/25.

Latanaprost eye drops and a Dulera inhaler with a pharmacy label for resident #11 were present on the medication cart on 6/10/25; however, there are no current orders for these medications listed on resident #11's 6/2025 medication administration record (MAR).

Bisacodyl 10mg suppositories with a pharmacy label for resident #12 was present in the medication cart; however, there are no current orders for this medication listed on resident #12's 6/2025 MAR.

Plan of Correction ***Accept [redacted]S - 07/25/2025)***

- *In May 2025, the community transitioned to a new EMAR system, transferring all existing physician orders into the new system. During this process, several discontinued orders were also inadvertently transferred into the new EMAR.*
- *On 6/10/2025, during the DHS inspection, a pharmacy consultant contracted by the community was on-site actively auditing the medication carts and a report was provided.*
- *Medication carts were audited on 6/26/25 by two 11p–7a nurse supervisors, and any medication issues identified were promptly corrected*
- *The Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of:*
  - *Verifying medications at the time of administration,*
  - *Checking expiration dates,*
  - *Ensuring that only medications with current, active physician orders are administered, and*
  - *Confirming that these medications are properly available and documented in the medication cart.*
- *11p–7a nurse supervisors will conduct monthly audits, reviewing one medication cart per week, to ensure continued compliance and accuracy.*
- *The community's contracted pharmacy consultant will audit all medication carts quarterly and provide a detailed report.*
- *The Director of Health and Wellness, Assistant Director of Health and Wellness, or designee will review these reports and address any identified issues or concerns to maintain compliance and resident safety.*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

183e - Storing Medications

17. 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

On 6/10/25, a bottle of low dose 81 mg Bayer non-chewable aspirin was found in the medication cart for resident #10. The manufacturers expiration date printed on the bottle is 12/2023.

Resident #11 is prescribed a Wixela 250-50 Inhub (Advair 2250-50 Diskus)- use 1 inhalation by mouth every 12 hours as needed. There is no open date on this inhaler. Per manufacturer's instructions, this medication should be discarded 30 days after being removed from the foil packet.

A Lantus pen prescribed to resident #13 with an open date of 4/7/25 was found in the medication cart on 6/10/25. Per manufacturer's instructions, the unused medication in the pen should be discarded 28 days after opening.

Lorazepam 0.5mg/10/25ml syringes prescribed to resident #14 were found in the medication cart on 6/10/25. These syringes expired on 5/21/25.

A bottle of Acetaminophen 325mg, prescribed for Resident #15 was found in the medication cart on 6/10/25, however the manufacturers expiration date printed on the bottle is 3/19/25.

Resident #16's Tramadol blister card was observed to have a punctured blister foil with the medication still present in the spot.

Repeat Violation Date: 1/29/24 et al.

Plan of Correction ***Accept [redacted] - 07/25/2025)***

- *On 6/10/2025, during the DHS inspection, a pharmacy consultant contracted by the community was on-site actively auditing the medication carts and a report was provided.*
- *All medication issues outlined above were corrected by 7/11/25 to ensure compliance with physician orders, resident safety, and regulatory requirements.*
- *Medication carts were audited on 6/26/25 by two 11p–7a nurse supervisors, and any medication issues identified were promptly corrected*
- *The Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of:*
  - *Verifying medications at the time of administration,*
  - *Checking expiration dates,*
  - *Ensuring that only medications with current, active physician orders are administered, and*
  - *Confirming that these medications are properly available and documented in the medication cart*
- *Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of verifying medications at the time of administration, expiration dates, ensuring that only medications with current, active orders are administered and that these medications are properly available and documented in the medication cart.*
- *11p–7a nurse supervisors will conduct monthly audits, reviewing one medication cart per week, to ensure continued compliance and accuracy.*
- *The community's contracted pharmacy consultant will audit all medication carts quarterly and provide a detailed report.*

183e - Storing Medications (continued)

- *The Director of Health and Wellness, Assistant Director of Health and Wellness, or designee will review these reports and address any identified issues or concerns to maintain compliance and resident safety*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

185a - Implement Storage Procedures

18. 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 #9 is prescribed blood glucose checks. On 6/8/25 at 3:50pm, a reading of 186 was recorded in their glucometer while a reading of 182 was recorded on the resident's medication administration record.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

- *On 6/10/2025, during the DHS inspection, a pharmacy consultant contracted by the community was on-site actively auditing the medication carts and a report was provided.*
- *All medication issues outlined above were corrected by 7/11/25 to ensure compliance with physician orders, resident safety, and regulatory requirements.*
- *Medication carts were audited on 6/26/25 by two 11p–7a nurse supervisors, and any medication issues identified were promptly corrected.*
- *Narcotic count sheet was reviewed on 6/26/25 and missed documentation was noted and corrected.*
- *The Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of:*
  - *Verifying medications at the time of administration,*
  - *Checking expiration dates,*
  - *Ensuring that only medications with current, active physician orders are administered, and*
  - *Confirming that these medications are properly available and documented in the medication cart.*
- *Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of verifying medications at the time of administration, expiration dates, ensuring that only medications with current, active orders are administered and that these medications are properly available and documented in the medication cart.*
- *11p–7a nurse supervisors will conduct monthly audits, reviewing one medication cart per week, to ensure*

185a - Implement Storage Procedures (continued)

continued compliance and accuracy.

- *The community's contracted pharmacy consultant will audit all medication carts quarterly and provide a detailed report.*
- *The Director of Health and Wellness, Assistant Director of Health and Wellness, or designee will review these reports and address any identified issues or concerns to maintain compliance and resident safety*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

187a - Medication Record

19. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #18 is prescribed Novolog Flexpen as per the following sliding scale, before breakfast, lunch and dinner: 150-200= 2 units, 201-250= 4 units, 251-300- 6 units, 301-350= 8 units, 351-400= 10 units, call over 400.
The resident's 6/2025 MAR does not indicate the number of units of Novolog administered to the resident for any date.

Plan of Correction ***Accept ([redacted]/25/2025)***

- *Medication carts and EMAR documentation were audited on 6/26/25 by two 11p–7a nurse supervisors, and any medication issues identified were promptly corrected*

187a - Medication Record (continued)

- *The Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of:*
  - *Accurate documentation on the medication cart EMAR*
- *11p–7a nurse supervisors will conduct monthly audits, reviewing one medication cart, EMAR documentation and orders per week, to ensure continued compliance and accuracy.*
- *The Director of Health and Wellness, Assistant Director of Health and Wellness, or designee will review reports of monthly audits and address any identified issues or concerns to maintain compliance and resident safety*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

187d - Follow Prescriber's Orders

20. Requirements

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

Description of Violation

Resident #9 is prescribed blood sugar checks four times per day; however, the home is only checking the resident's blood sugar three times per day.

Resident #9 is prescribed an order for wound care- change right leg dressing daily. This care was not recorded as being completed for any date on the resident's 6/2025 medication administration record. Interviews with staff members indicate that is not clear between staff who should be completing this wound care.

Plan of Correction

Accept [redacted] /25/2025)

- *In May 2025, the community transitioned to a new EMAR system, transferring all existing physician orders into the new system. During this process, several discontinued orders were also inadvertently transferred into the new EMAR.*
- *Resident #9 blood sugar checks and wound care orders were clarified by Assistant Director of Health and Wellness on 7/11/25.*
- *The Assistant Director of Health and Wellness will educate all med techs by 7/31/25 on the importance of:*
  - *Verifying orders*
  - *Notifying nurse or Assistant Director of Health and Wellness if orders are in question*
- *11p–7a nurse supervisors will conduct monthly audits, reviewing one medication cart and review orders per week, to ensure continued compliance and accuracy.*
- *The community's contracted pharmacy consultant will audit all medication carts quarterly and provide a detailed report.*
- *The Director of Health and Wellness, Assistant Director of Health and Wellness, or designee will review these reports and address any identified issues or concerns to maintain compliance and resident safety*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/05/2025)

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

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *06/02/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

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

Administrator

Name: [redacted]

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *I-2* **Date**: *12/02/2016* **Issued By**: *East Pikeland Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *106* **Waking Staff**: *80*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/16/2025*

Inspection Dates and Department Representative

06/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *86*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *16*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

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

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

Inspections / Reviews

06/16/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2025*

07/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/22/2025*

07/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/03/2025*

09/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Staff person A worked in the home as a care manager since August of [redacted] Residents #1, #2, and at least one other resident requested staff person A stay out of their rooms and that other staff provide their care. These residents found staff person A to be rough and impatient. Resident #1 said that the staff person hurt them while assisting with transferring in and out of bed and chair. Resident #2 said the staff person made them fear injury while showering.

Around January or February of 2025, staff person B, a healthcare coordinator, was called to resident #1's room to address a complaint from the resident regarding staff person A. Staff person B asked resident #1, with staff person A and other staff present, whether they wanted staff person A in their room. Resident #1 told staff person A directly not to enter the room anymore. Staff person B instructed staff person A to stay out of the room and to switch with another care manager if assigned to resident #1 in the future.

On 5/28/2025 at 3:39 pm, resident #1 rang their call bell for assistance. Staff person C, [redacted], told staff person A in the nursing station that staff person C would answer the call bell once they finished escorting another resident to the first floor. However, when staff person C stepped away, staff person A entered resident #1's room, acknowledged they weren't supposed to be there. Staff person C arrived and confronted staff person A about being in the room with resident #1 present. Staff person A was [redacted] and then [redacted] d.

Plan of Correction Repeat Violation Date: 8/26/24 ***Directed [redacted] - 07/22/2025)***

- *Staff person B did not report any concerns or issues that Resident #1 had with Staff person A to the Director of Health and Wellness or the Executive Director in or around January or February 2025.*
- *At no time did Resident #1 or Resident #2 report any concerns or issues regarding Staff person A to the Executive Director.*
- *On June 1, 2025, representatives from the Office of Aging entered the community and met with the Executive Director to discuss complaints they had received concerning Staff person A.*
- *Upon receipt of the accusations on June 1, 2025, the Executive Director [redacted] Staff person A pending further investigation.*
- *On June 1, 2025, the Executive Director initiated an investigation and conducted interviews with Staff persons A, B, and C, as well as Residents #1 and #2.*
- *Staff person B did not report any concerns or issues that Resident #1 had with Staff person A to the Director of Health and Wellness or the Executive Director in or around January or February 2025.*
- *At no time did Resident #1 or Resident #2 report any concerns or issues regarding Staff person A to the Executive Director or Assistant Director of Health and Wellness.*
- *On June 6, 2025, Staff person A contacted the Business Office Manager and stated that they would be resigning from employment effective immediately.*
- *The Assistant Director of Health and Wellness will provide education to the nursing staff on the requirement to immediately report any resident-reported concerns to management by July 31, 2025.*
- *Education on the requirement to immediately report any resident-reported concerns to management will be incorporated into new hire orientation, beginning with the next scheduled session conducted by the Business Office Manager in August 2025.*
- *Education on Resident Rights will be a required training module within the community training program, to*

42c - Treatment of Residents (continued)

be completed by all staff on a quarterly basis beginning September 2025.

- *The Executive Director will conduct monthly check-ins with randomly selected residents to discuss any questions or concerns related to staffing beginning August 1 2025.*

Proposed Overall Completion Date: 08/01/2025

Directed steps of POC:

Immediately: *The administrator shall privately interview at least five residents a week for three months and biannually thereafter to ensure residents are treated with dignity and respect. Documentation of interviews shall be kept.*

Within 10 days of the receipt of the plan of correction: *All direct care staff, ancillary staff persons, substitute personnel, volunteers and management staff including the administrator shall receive training in abuse reporting and prevention and resident rights from a Department-approved outside source. Documentation of training shall be kept in accordance with 2600.65i.*

Directed Completion Date: *08/01/2025*

Not Implemented [redacted] - 09/09/2025)

85d - Trash Receptacles

2. 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

There was a full, uncovered, unattended trash can in the main kitchen.

Plan of Correction ***Accept [redacted] - 07/18/2025)***

- *On 6/16/25, during the DHS inspection, it was noted that a trash can did not have a lid on it.*
- *Director of Culinary immediately corrected the issue by placing a lid on the trash can.*
- *Director of Culinary will add a step to the daily cook checklist to verify that all trash cans are properly covered.*
- *On 6/29/25, the Director of Culinary ordered several trash cans with lids that are not detachable to help ensure trash is always covered and to support ongoing compliance with sanitation requirements.*
- *Director of Culinary will educate all dining staff by 7/31/25 on the importance of keeping trash cans covered at all times to maintain sanitation and regulatory compliance.*
- *The Director of Culinary will monitor the daily checklist to ensure compliance and confirm that these checks are being completed consistently.*

85d - Trash Receptacles *(continued)*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Not Implemented [redacted] - 09/09/2025)

86b - Bathroom

3. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathrooms in rooms 160, 207, 254, 260 did not have operable windows or ventilation fans.

Plan of Correction ***Accept ([redacted] - 07/22/2025)***

- *On June 16, 2025, it was noted during DHS inspection that the bathroom fans were not operating properly in apartments 160, 207, 254, and 260. The Director of Maintenance was not aware of these issues until that date..*
- *Director of Maintenance investigated the issue on June 17, 2025 and found an issue with the exhaust fan motor for half of the community is not operating properly and continues to shut off.*
- *Director of Maintenance was able to repair the exhaust fan motor on June 27, 2025.*
- *Director of Maintenance noted on July 3, 2025 the exhaust fan motor was not operating properly.*
- *Director of Maintenance contacted HVAC company on July 9,2025 to obtain a quote to have the fan motor replaced.*
- *Awaiting quote and date of repair.*
- *Director of Maintenance will continue to monitor the exhaust motor fans to ensure they are working properly*

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

Not Implemented ([redacted] 09/09/2025)

103f - Refrigerator/Freezer Temps

4. 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 the deep freezer in the main kitchen.

Plan of Correction ***Accept ([redacted] - 07/18/2025)***

- *On 6/16/25, during the DHS inspection, it was noted that the thermometer for the deep freezer was missing.*
- *The Director of Culinary immediately corrected the issue by placing a new thermometer in the deep freezer.*
- *The Director of Culinary will add thermometer checks to the daily cook checklist by 8/1/25.*
- *The Director of Culinary will educate all cooks on this new requirement by 7/31/25.*
- *The Director of Culinary will monitor the daily checklist to ensure compliance and verify that thermometer checks are being completed consistently.*

Licensee's Proposed Overall Completion Date: *08/01/2025*

Not Implemented ([redacted] - 09/09/2025)

103f - Refrigerator/Freezer Temps *(continued)*

103g - Storing Food

5. Requirements

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

Description of Violation

There was a tub of ice cream in the main freezer whose lid wasn't sealed.

Plan of Correction ***Accept ([redacted] - 07/18/2025)***

- *On 6/16/25, it was noted that the lid on a tub of ice cream delivered by the food supplier was torn.*
- *Director of Culinary immediately replaced the lid on 6/16/25 to ensure the ice cream was properly sealed.*
- *Director of Culinary will educate all dining staff by 8/8/25 on the importance of inspecting food upon delivery, to ensure that all items from the supplier are intact, undamaged, and meet safety standards.*
- *Dining staff will report any concerns with Director of Culinary.*
- *Director of Culinary will check food storage areas weekly to ensure food is stored in sealed containers and not damaged.*

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

Not Implemented [redacted] - 09/09/2025)

105g - Lint Removal and Duct Cleaning

6. 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

There was an accumulation of lint in the lint traps of two dryers in the laundry room. There were no clothes in the dryers at the time.

Plan of Correction ***Accept [redacted] - 07/18/2025)***

- *On 6/16/25, at the time of inspection, it was noted that two dryers had an accumulation of lint in the lint traps.*
- *The Director of Maintenance immediately cleaned the lint traps on 6/16/25 to correct the issue.*
- *Resident laundry is completed during the 11p–7a shift by staff members.*
- *Additionally, residents are permitted to wash their own laundry, which may also contribute to lint accumulation.*
- *Director of Maintenance will discuss the importance of cleaning lint traps and dryer safety with residents during the monthly Resident Council meetings, to help ensure residents who do their own laundry understand how to prevent lint buildup and reduce fire risk.*
- *Director of Maintenance will educate nursing staff on the importance of cleaning lint traps and overall dryer safety by 8/8/25, ensuring they understand how to prevent lint buildup and reduce fire risk.*
- *Director of Maintenance will also add checking lint traps in the residential laundry rooms to the housekeeping duties by 8/8/25, to support ongoing compliance and safety.*
- *Director of Maintenance will periodically check the residential laundry dryers to ensure compliance with lint*

105g - Lint Removal and Duct Cleaning (continued)

trap cleaning and overall dryer safety protocols.

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

Not Implemented ([redacted] - 09/09/2025)

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *06/02/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

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

Administrator

Name: [redacted]

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/28/2025*

Inspection Dates and Department Representative

08/28/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *18*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

08/28/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/23/2025*

09/24/2025 - POC Submission

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

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

Inspections / Reviews *(continued)*

10/01/2025 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/11/2025*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] 2025, resident #1 was sent out to an ER via ambulance and was treated for heat exposure/suspected heat stroke. The home did not report this incident to the department.

Plan of Correction ***Accept ([redacted] - 10/01/2025)***

- The new Executive Director/Administrator sent the report to the state on 9/19/2025.
- The Executive Director/Administrator provided training for the leadership team on 9/22/2025 to ensure they understand the new reporting protocols and their roles in compliance.
- A comprehensive training session will be conducted for the entire nursing team on 9/30/2025 by the Executive Director/Administrator to reinforce the importance of reporting procedures. In addition, the Director of Health and Wellness and the Assistant Director of Health and Wellness are currently conducting an in-service with each shift, which will be completed by 9/26/2025.
- The Executive Director/Administrator and the Director of Health and Wellness will provide quarterly documented training sessions to ensure the nursing team remains compliant with regulations and is up-to-date on best practices.
- The Executive Director/Administrator will conduct documented audits of incident reports and compliance documentation on a monthly basis for the first three months, with the first monthly audit scheduled for 10/8/2025. This will help identify any areas needing improvement and ensure accountability. Following this initial period, audits will shift to a quarterly schedule, conducted by the Executive Director/Administrator.

(see the attached supporting documentation)

Licensee's Proposed Overall Completion Date: *10/10/2025* Not Implemented [redacted] - 10/15/2025)

17 - Record Confidentiality

2. 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 08/28/2025 at 09:34 AM, the home's 2nd floor nurses station was unlocked, unattended, and accessible. Residents' charts were observed shelved on the wall facing the door. Repeat Violation Date: 8/26/24, 1/29/24 et al.

Plan of Correction ***Accept [redacted] 10/01/2025)***

- The nurse station was secured immediately upon discovery on 8/28/2025.
- An in-service was created on 9/22/2025, by the Executive Director/Administrator for the entire leadership team to communicate that the nurse station door must remain locked at all times to ensure privacy, confidentiality, data protection, and the importance of securing sensitive information in accordance with HIPAA regulations. In addition, the Director of Health and Wellness and the Assistant Director of Health and Wellness are currently conducting an in-service with each shift, which will be completed by 9/26/2025. All staff will be retrained by 9/30/2025 during the scheduled mandatory all staff meeting.

17 - Record Confidentiality (continued)

- Starting on 9/25/2025, the Director of Health and Wellness, and/or the Assistant Director of Health and Wellness, and the Memory Care Coordinator will conduct random checks of the nurse station on a weekly basis for the first four weeks to ensure compliance with the new record protection measures. After this initial period, the checks will transition to a monthly schedule. All documentation from these checks will be maintained for review.
- A sign has been placed on the nurse station door indicating that the door must be locked at all times when unattended, serving as a reminder for staff to secure the area. In addition, an automatic closer door mechanism will be installed on the door by 10/2/2025.

(see the attached supporting documentation)

Licensee's Proposed Overall Completion Date: *10/10/2025* **Not Implemented [redacted] 10/15/2025)**

42b - Abuse

3. 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

Resident #2 and #3 resided in the home's Secured Dementia Care Unit (SDCU). Resident #3, who did not have a diagnosis of dementia, lived there to be with resident #2, whose dementia had progressed and who had a tendency to wander. Verbal aggression towards resident #2 was observed and documented in resident #3's assessment and support plan (RASP) dated 0[redacted]/2025.
On 0[redacted]/2025 during dinner time, resident #2 and resident #3 were having dinner together in the dining room. Resident #2 kept standing up from the dinner table and resident #3 kept yelling at [redacted] to sit down and finish dinner. Their interaction became too disruptive, and staff had to remove resident #2 from the dining room to the activity space nearby. Resident #3 followed and yelled. When staff A heard the commotion, they alerted the other two staff, B and C, by saying "They are fighting." By the time staff B and C ran to room [redacted], the two residents were coming out of room [redacted] and resident #3 pushed resident #2, who fell forward without bracing [redacted] and hit the head (left side) hard on the floor, resulting in scalp laceration and head bleeding. Around 06:45 PM, resident #2 was sent out to a hospital via 911 and [redacted] away on [redacted]/2025. The death verification form from the Coroner's office listed the cause of death as Sequelae of Acute Subdural Hematoma, due to Blunt Trauma to Face and Head with a manner of death as being a homicide.

On 07/25/2025 around 04:00 PM, resident #1 was observed sitting outdoors and was clammy, woozy, and presented with altered mental status after sitting outside for approximately 3 hours at the home's patio. The resident was sent out to an ER via ambulance. The high temperature outdoors at 03:51PM was reported as 95 degrees Fahrenheit; an extreme heat warning was broadcasted through emergency services in all counties surrounding Philadelphia reporting an expected heat index of 108°F. The hospital visit summary listed the reason for visit as heat exposure/suspected heat stroke. The resident's body temperature at admission was 102.6°F. The home's staff last checked on the resident around 02:30 PM. The resident had a similar episode in August 2024 and and was hospitalized and received treatment for dehydration and acute kidney injury from [redacted]/2024 till [redacted]/2024. Resident #1's most recent assessment and support plan, dated 02/18/2025, states:

42b - Abuse (continued)

"[Resident] requires moderate supervision in the home and needs assistance when outside on the patio/outside of the community." The resident's prior assessment and support plan, dated 02/27/2024, was updated 08/2024 stating "monitor resident when sitting outside on porch for dehydration."

Plan of Correction

Accept [redacted] - 10/01/2025)

- The Executive Director/Administrator conducted a training session for the leadership team focused on the regulation regarding communication protocols when challenging behaviors occur on 9/22/2025. The training emphasized the importance of effective communication with the Executive Director/Administrator when challenging behaviors arise It is essential that these behaviors are communicated not only to families but also to the nursing team and the regional team to foster collaboration in ensuring residents' safety including possible discharge. The Executive Director/Administrator highlighted the critical need to review medication lists, support plans, and maintain open lines of communication with the residents' doctors to provide the best care possible. The DHW and ADHW will be responsible for ongoing training, reviewing the support plan, and making updates as necessary.
- The Executive Director/Administrator will conduct weekly meetings with the nursing leadership to discuss concerns, including behaviors affecting resident care, staffing challenges, and any necessary adjustments to care plans. These meetings will serve as a platform for collaboration and problem-solving to enhance the quality of care provided to residents. The first meeting is scheduled for 9/26/2025. During this initial session, the Executive Director/Administrator will outline the agenda and expectations for ongoing discussions, focusing on addressing concerns related to resident behaviors, staffing issues, and overall care strategies. Minutes for these meetings will be kept.
- The Executive Director/Administrator reviewed and updated Resident #1's care plan to ensure it clearly outlines the redirection techniques to be used when the resident is outdoors, and frequent checks were added on 9/22/2025. This update was made during a retraining session for the nursing leadership team, emphasizing the importance of following individualized care plans and effectively implementing strategies to keep residents safe and hydrated. The DHW and ADHW will be responsible for ongoing training, reviewing the support plan, and making updates as necessary.
- The Executive Director/Administrator will conduct a mandatory training session for all staff on the importance of implementing individualized care plans, particularly redirection techniques and frequent checks for residents with specific needs. This training will emphasize the case of Resident #1 and will be completed on 9/30/2025. In addition, the Director of Health and Wellness and the Assistant Director of Health and Wellness are currently conducting an in-service with each shift, which will be completed by 9/26/2025.
- The Director of Health and Wellness and the Memory Care Director will implement a centralized log on 9/30/2025 to record instances of challenging behaviors, communication with families, and adherence to individualized care plans. This log will be updated regularly by nursing staff and reviewed during weekly clinical meetings. Regular feedback will be gathered from staff during these meetings, and we will review incident reports related to challenging behaviors to assess the effectiveness of the training. The Director of Health and Wellness will hold nursing meetings monthly, with the first one scheduled for 10/6/2025.

(see the attached documentation)

Licensee's Proposed Overall Completion Date: *10/10/2025* Not Implemented [redacted] - 10/15/2025)

102i - Soap Dispenser

4. 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 08/28/2025 around 09:30 AM, there was an unlabeled used bar of soap in the shower stall in resident room [redacted] which was shared by two residents.

Plan of Correction ***Accept [redacted] - 10/01/2025)***

- The soap was removed immediately upon discovery on 8/28/2025.
- The Executive Director/Administrator conducted training for the Director of Facilities and the Memory Care Director on 9/22/2025. This training focused on the importance of conducting weekly and monthly inspections in the shared bathrooms. The goal is to ensure that there are no unlabeled or unsecured hygiene items present, thereby maintaining a safe and hygienic environment for all residents.
- The housekeeping checklist has been reviewed and updated to include a specific item for housekeepers to check for unsecured hygiene items. The checklist will be completed daily by housekeeping staff starting on 10/1/2025. Each completed checklist will be submitted to the Memory Care Director for review.
- The Memory Care Director will conduct weekly inspections for the first four weeks starting on 9/25/2025, using the updated checklist to verify compliance. After this initial period, the Memory Care Director will conduct monthly checks to ensure ongoing compliance until substantial compliance has been met.
- A training for both housekeepers and the nursing team will take place on 9/30/2025 during our all-staff meeting to reinforce these protocols and ensure comprehensive understanding across all departments.

(see the attached supporting documentation)

Licensee's Proposed Overall Completion Date: *10/10/2025* Not Implemented [redacted] - 10/15/2025)

141b1 - Annual Medical Evaluation

5. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted] /2024. The resident's previous medical evaluation was completed on [redacted] /2022. Repeat Violation Date: 6/11/24, 1/29/24 et al.

Plan of Correction ***Directed ([redacted] - 10/01/2025)***

- The Executive Director/Administrator trained on the importance of timely medical evaluations in accordance with regulatory requirements during a meeting with the Director of Health and Wellness, the Assistant Director of Health and Wellness, and the Memory Care Director on 9/22/2025. This training focused on ensuring that medical evaluations are completed annually and/or following any significant changes in residents' conditions. By clarifying these responsibilities, we aim to enhance compliance and improve the quality of care for all residents.
- The DHW, ADHW, and the MCD will develop and implement a digital tracking system to monitor the scheduling and completion of medical evaluations for all residents by 10/6/2025.
- The DHW, ADHW, and MCD will conduct monthly audits for a duration of six months to review the completion of RASP and DME for all residents. Each month, the MCD will audit 25% of the residents in the Memory Care Unit, while the DHW and ADHW will audit 25% of the residents on the personal care side.

141b1 - Annual Medical Evaluation (continued)

- The DHW, AHDW, and the MCD will conduct an intensive review of all RASPs and DMEs by 10/6/2025 to identify accuracy and the need for changes or follow-up. By 10/30/2025, all RASPs and DMEs must be in compliance.
- The Executive Director/Administrator will review and document the status of medical evaluations for all residents quarterly to ensure compliance with the revised policies and procedures.

(see the attached supporting documentation)

Proposed Overall Completion Date: 10/30/2025

Directed Plan of Correction [redacted] - 10/1/25): Only the overall completion date has been directed to 10/10/25

Directed Completion Date: *10/10/2025*

Not Implemented [redacted] - 10/15/2025)