



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 2, 2025

Emeritus Corporation
[REDACTED]

RE: Brookdale Harrisburg
3560 North Progress Avenue
Harrisburg, Pennsylvania 17110
License/COC #: 316111

Dear Emeritus Corporation:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 16, 2025, July 8, 2025, July 9, 2025 and July 10, 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 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) ;(5) 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 October 2, 2025 to April 2, 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.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
183(b)	III	40	\$3	\$120	15 days from the mailing date of this letter
185(a)	II	40	\$5	\$200	5 days from the mailing date of this letter
187(c)	III	40	\$3	\$120	15 days from the mailing date of this letter
187(d)	II	40	\$5	\$200	5 days from the mailing date of this letter
233(c)	III	40	\$3	\$120	15 days from the 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:


 Pennsylvania Department of Human Services

Bureau of Human Services Licensing
Forum Place
555 Walnut Street
6th Floor
Harrisburg, Pennsylvania 17101
PH: 717-265-8942

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,

A handwritten signature in black ink that reads "Juliet Marsala". The signature is written in a cursive, flowing style.

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *BROOKDALE HARRISBURG* License #: *31611* License Expiration: *01/09/2026*
Address: *3560 NORTH PROGRESS AVENUE, HARRISBURG, PA 17110*
County: *DAUPHIN* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *EMERITUS CORPORATION*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/20/1997* Issued By: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *86* Waking Staff: *65*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *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: *65* Residents Served: *43*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *24* Residents Served: *7*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *43*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *43* Have Physical Disability: *0*

Inspections / Reviews

06/16/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/18/2025*

08/20/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/15/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/27/2025

09/03/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/15/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 09/15/2025

09/23/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/15/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

16c - Written Incident Report (continued)*Proposed Overall Completion Date: 11/18/2025**Proposed Overall Completion Date: 08/28/2025**Licensee's Proposed Overall Completion Date: 09/03/2025**Implemented [REDACTED] - 09/19/2025)***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 #1 was admitted to the home on [REDACTED]/25, the home failed to complete a written initial assessment for the resident. Additionally, resident #1's preadmission screening form dated [REDACTED]/24 does not include a determination that the needs of the resident can be met by the services provided by the home.

On 5/28/25 resident #1 was sent to the emergency room due to the discovery of wounds on the ischium and right buttocks area. The resident was diagnosed with a stage II gluteal ulcer, which required wound care. On 5/29/25, the home was instructed by the home health care giver on the use of pressure-relieving devices to commensurate with the degree of skin breakdown. However, the home failed to acquire a pressure-relieving device for the resident. The home health care agency also gave additional instructions to the home and home's staff to include the following:

- "Instructed patient/caregiver to limit chair sitting to 2 hours at any one time "*
- "Instructed patient/caregiver to keep skin clean and dry especially over bony prominences, twice daily or as indicated by incontinence or sweating"*

The visit note report from the home health agency dated 5/29/25 indicated that the caregiver demonstrated competency performing appropriate wound care AEB return demonstration as instructed by clinician.

Reports from the early morning hours of [REDACTED] 25, indicate that the staff member B who was responsible for checking on resident #1 and changing [REDACTED] brief refused to perform these tasks due to the odor coming from the resident's room. The last documented time that resident #1 was checked and changed was around 1:00 AM on 6/7/25. On 6/7/25, at approximately 8:00 AM, staff member A discovered resident #1 soaked in urine and feces, the resident was stiff, rigid and experiencing severe pain. The resident was sent to the emergency room and was diagnosed with sepsis, pneumonia to the right lower lobe, fever, hypoglycemia, high concern for Fournier's gangrene and necrotizing fasciitis. The resident was taken to surgery and was later admitted to the intensive care unit. Resident #1 was hospitalized until [REDACTED]/25, when [REDACTED] was transferred home with a family member where [REDACTED] was receiving hospice care. Resident #1 ceased to breathe on [REDACTED]/25.

Plan of Correction*Directed [REDACTED] - 09/03/2025)*

6/11/25 - Med Techs and Care Partners were educated by Bayada Home Health related to skin care and prevention of skin break down

8/18/25 - HWD and Clinical Support Specialist will complete audits of Resident Skin assessments weekly for 4

42b - Abuse (continued)

weeks and then monthly for 2 months.

The ED will review the results of these audits to verify if any further action is warranted.

(Directed)

-Effective 9/15/25, the ED will review the results of the Residential Skin Assessments on a weekly basis to ensure proper follow-up is being completed and appropriate care is being provided. The ED will address any refusals of these assessments upon their discovery.

Proposed Overall Completion Date: 09/15/2025

Directed Completion Date: 09/15/2025

Not Implemented [redacted] - 09/19/2025)

81a - Accommodation

4. Requirements

2600.

81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

On [redacted] 8/25, resident #1 was sent to the emergency room by the home, due to the discovery of wounds on the ischium and right buttocks area. The resident was diagnosed with a stage II gluteal ulcer, which required wound care. On 5/29/25, the home was instructed by the home health care giver on the use of pressure-relieving devices to commensurate with the degree of skin breakdown. However, the home failed to acquire a pressure-relieving device for the resident.

Plan of Correction

Accept [redacted] - 09/03/2025)

6/11/25 - Med Techs and Care Partners were educated by Bayada Home Health related to skin care and prevention of skin break down.

8/18/25 - Skin assessments will be conducted by HWD and Clinical Care Specialists and audits will be completed of the assessment for four weeks and then monthly for 2 months. If a pressure area is identified the proper care will be coordinated by the community clinical team.

Proposed Overall Completion Date: 11/18/2025

Proposed Overall Completion Date: 08/28/2025

Licensee's Proposed Overall Completion Date: 09/03/2025

Not Implemented [redacted] - 09/19/2025)

187d - Follow Prescriber's Orders

5. Requirements

2600.

187d - Follow Prescriber's Orders (continued)

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

Description of Violation

Resident #1 is prescribed the following medications:

- Bumex Oral Tablet 0.5mg give 1 tablet by mouth one time a day for CHF.
- Levothyroxine Sodium tablet 150 MCG, give 1 tablet by mouth one time a day for low thyroid hormone.
- Zoloft Oral Tablet 2mg, give 1 tablet by mouth one time a day for depression

However, on 5/8/25 the resident was not administered these medications.

Resident #1 is prescribed the following medications:

- Amiodarone HCl Oral Tablet 200mg, give 1 tablet by mouth one time a day for afib.
- Apixaban 5mg Give 1 tablet by mouth two times a day for afib.
- Ferrus Sulfate Oral Tab 325mg, give 1 tablet by mouth two times a day for supplement.
- Ropinirole HCl Oral Tab 2mg, give 1 tablet by mouth two times a day for Parkinson's.
- Torpol XL Extended Release 24 Hour 25mg, give 0.5 tablet by mouth two times a day for afib.
- Tylenol Oral tablet 325mg give 2 tablets by mouth 3 times a day for pain or fever.

However, on 5/8/25 and 6/6/25 at 8:00 AM the resident was not administered these medications.

Resident #2 was prescribed Methylprednisolone tablets USP 4 mg, 6-day taper, give 6 tablets by mouth one time a day for joint pain/RA for 1 day. On 3/24/25, resident was administered only 5 out of the 6 tablets.

Resident #3 is prescribed Percocet, oral tablet 10-25mg (Oxycodone w/ Acetaminophen), give 2 tablets by mouth four times a day for moderate pain. However, resident #3 was administered 1 pill on 3/16/25 at 6:00 AM.

Plan of Correction Repeated Violation - 7/10/24, et al Accept [REDACTED] - 08/20/2025

7/21/2025 - Direct clinical staff will be retrained on the regulation and community policies and procedures regarding following the directions of the prescriber. When medications are not able to be administered as ordered medical technicians and clinical staff must immediately notify the HWD/or designee and prescriber.

7/13/2025- Preferred pharmacy completed a full house medication cart audit to verify medications were available per physician orders.

8/18/2025- To assist with ongoing compliance, the HWD or designee will audit the MAR's weekly for three (3) months to verify that ordered medications are administered to the residents.

The ED or designee will review the results of these audits to verify compliance.

Licensee's Proposed Overall Completion Date: 11/18/2025

224a - Preadmission Screen Form

6. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form (continued)

Description of Violation

Resident #1's preadmission screening form, dated [REDACTED]/24, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction Repeated Violation - 7/10/24, et al **Accept** [REDACTED] - 09/03/2025)

8/19/25 - ED provided education to the HWD and Clinical Care Specialist on the need to complete all areas of the pre-screen

8/19/25 - ED or HWD will audit pre-screens for accuracy and completion for 4 weeks and then monthly for 3 months.

Proposed Overall Completion Date: 11/18/2025

Proposed Overall Completion Date: 08/28/2025

Licensee's Proposed Overall Completion Date: 09/03/2025

Not Implemented [REDACTED] - 09/19/2025)

225a - Assessment 15 Days

7. Requirements

2600.

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

Description of Violation

An assessment was not completed for resident #1, who was admitted to the home on [REDACTED]/25.

Plan of Correction Repeated Violation - 7/10/24, et al **Accept** [REDACTED] - 09/03/2025)

8/19/25 - Executive Director provided education to the HWD and Clinical Specialist on the need to complete the assessments timely.

8/19/25 - Audits of assessment completion will be completed weekly for 4 weeks and monthly for 2 months by the HWD or designee

The ED will review the results of these audits to verify if any further action is warranted.

Proposed Overall Completion Date: 11/18/2025

Proposed Overall Completion Date: 08/28/2025

Licensee's Proposed Overall Completion Date: 09/03/2025

Not Implemented [REDACTED] - 09/19/2025)

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

Facility Information

Name: *BROOKDALE HARRISBURG* License #: *31611* License Expiration: *01/09/2026*
Address: *3560 NORTH PROGRESS AVENUE, HARRISBURG, PA 17110*
County: *DAUPHIN* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *EMERITUS CORPORATION*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/20/1997* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *61* Waking Staff: *46*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Incident* Exit Conference Date: *07/10/2025*

Inspection Dates and Department Representative

07/08/2025 - On-Site: [REDACTED]
07/09/2025 - On-Site: [REDACTED]
07/10/2025 - On-Site: [REDACTED]
07/18/2025 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* Residents Served: *40*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *24* Residents Served: *8*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *24*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *21* Have Physical Disability: *0*

Inspections / Reviews

07/08/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/18/2025*

08/20/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *08/18/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/27/2025*

08/29/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *08/27/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *09/12/2025*

09/23/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *09/12/2025*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 7/8/25, at 10:00 AM, an agent of the Department requested the charts for the stratified sample chosen for the inspection and the past two weeks' worth of worked schedules. Staff person A provided the final requested records on 7/10/25 and the correct schedules on 7/9/25.

Plan of Correction

Directed [redacted] - 08/28/2025)

7/11/2025- Executive Director and Health & Wellness Director were educated by the DHS surveyor on the importance on providing requested documentation in a timely manner.

8/11/2025- Executive Director re-educated management staff on the DHS access requirement regulation to verify no delays for future DHS visits/ surveys.

8/27/25 - Executive Director will audit staff schedules weekly for 4 weeks to assure they are accurate and complete and then monthly for 2 months

[Directed]

- In addition to the steps above, the Executive Director will audit resident records to ensure resident records are easily accessible. These audits will start no later than 9/12/25 and will occur weekly for 4 weeks to assure they are accurate and complete and then monthly for 2 months. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 09/12/2025

Not Implemented [redacted] - 09/23/2025)

15a - Resident Abuse Report

2. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]/29/25, at 6:30 PM, resident #1 was seen hitting resident #2 in the face by staff person A. However, this incident was not reported to the local Area Agency on Aging.

Plan of Correction

Accept [redacted] - 08/28/2025)

7-21-2025 Executive director re-educated staff on community policy and state regulations for abuse reporting to the DHS and AAA, including completing an Act13 form.

8/11/2025- Executive Director will complete weekly x four (4) weeks and monthly x two (2) weeks, to verify abuse

allegations are reported and Act 13 forms are completed.
8/27/25 - Act 13 form forwarded to Dauphin County AAA for resident #2

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

Not Implemented - 09/23/2025)

17 - Record Confidentiality

3. 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 7/8/25, at approximately 10:30 AM, a note stating resident #1's and #5's Acrdophilus probiotic was in the fridge was taped to the top of the laptop located on top of the medication cart in the Secure Dementia Care Unit. This note was unlocked, unattended and accessible.

Plan of Correction

Accept - 08/28/2025)

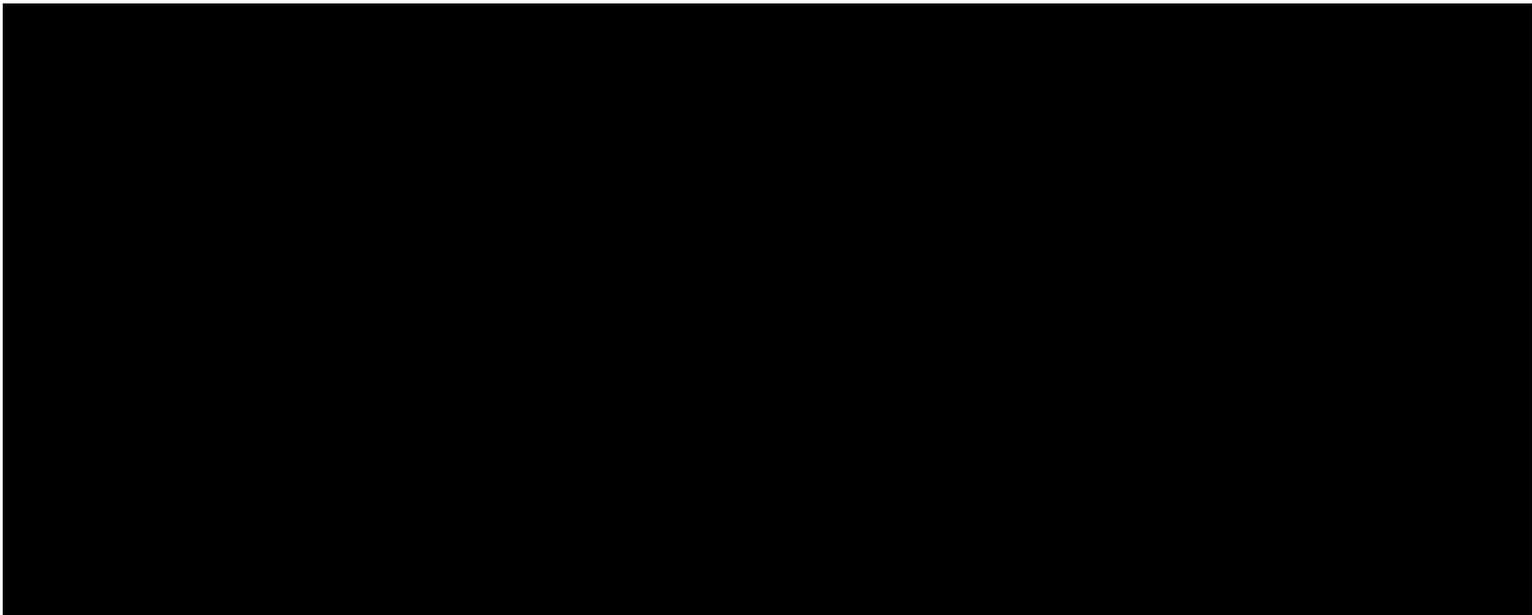
7/8/2025- HWC removed Information on the laptop was immediately and properly discarded.

7/21/25- ED provided re-education to the staff regarding confidentiality and privacy information for residents.

8/11/2025- Health and Wellness Director will complete weekly x four (4) weeks and monthly x (2) weeks to verify resident information is being kept confidential, and in secured areas per community policy.

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

Not Implemented - 09/23/2025)



63a - First Aid/CPR Training

5. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

From Saturday 6/21/25 at 11:00 PM to Sunday 6/22/25 at 7:00 AM, 41 residents were present in the home. However, during this time, there were no staff persons present in the home who were certified in CPR and First Aid.

Plan of Correction

Accept [redacted] - 08/29/2025)

7/11/2025- ED and or designee reviews work schedule weekly to verify a staff member has completed been certified in CPR and First Aid.

7/21/25 - Executive Director provided re-education to staff on the requirement to have at least one staff member CPR and First Aid certified for every 50 residents residing in the community.

7/26/2025- Staff CPR training provided for staff who did not have certifications. **(Directed) Staff First Aid training will also be provided to staff who did not have certifications 8/29/25 - [redacted]**

8/11/2025- ED and or designee will audit staff CPR trainings for expirations weekly x 4 week and monthly thereafter. **(Directed) Staff First Aid trainings will also be audited as part of the on-going audits 8/29/25 - [redacted]**

8/28/25 - Health and Wellness Director will review all staff to identify who does not have a CPR certification and First Aid Training and when staff certifications will expire.

Proposed Overall Completion Date: 09/12/2025

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

Not Implemented [redacted] - 09/23/2025)

65g - Annual Training Content

6. 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.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C, hired on [REDACTED]/23, did not receive the following training during the 2024 training year:

- 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.
- Resident rights.
- The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- Falls and accident prevention.
- New population groups that are being served at the home that were not previously served, if applicable.

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/21/2025- Executive Director re-educated staff including staff member "C" on the community policy to complete annual training.

7/21/2025- Staff person C's annual training education was reviewed for 2025 to verify completion within the year. Staff person C received identified education.

7/21/2025- Associate records were audited for compliance with annual training. Associates found out of compliance were assigned annual trainings to be completed for 2025.

8/11/2025- ED and or designee will audit staff annual education weekly x 4 weeks and monthly x 2 months to verify annual training completion.

8/28/25 - Executive Director will educate Business Office Manager on importance of reviewing staff training for yearly compliance.

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

Not Implemented [REDACTED] - 09/23/2025)

82a - Poisonous Materials

7. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 7/9/25, at 11:37 AM, there was an unlabeled spray bottle containing an unknown liquid located in the Secure Dementia Care Unit laundry room.

82a - Poisonous Materials (continued)

Plan of Correction

Accept [REDACTED] - 08/29/2025)

7/8/2025- The laundry room door was secured and the spray bottle immediately removed by the maintenance manager

7/8/2025- A thorough walk through was completed by the ED and Clinical Specialist in the SDCU to verify poisonous materials were labeled and secured.

7/23/2025- ED re-educated the SDU staff regarding the community policy to keep all poisonous materials properly stored, labeled and locked.

8/11/2025- ED and or designee will audits the SDU to verify poisonous materials are properly labeled, stored and locked weekly x 4 weeks and monthly x 2 months.

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

Not Implemented [REDACTED] - 09/23/2025)

82c - Locking Poisonous Materials

8. 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 [REDACTED]/25, room [REDACTED] of the Secure Dementia Care Unit (SDCU) was unlocked, unattended and accessible. The following items were located in room [REDACTED]

- ProHealth Toothpaste with a manufacture's label indicating "if accidentally swallowed get medical help or contact a poison control center right away" on the bathroom sink.
- A roll-on antiperspirant with a manufacture's label indicating "if accidentally swallowed, get medical help or contact a poison control right away" in an unlocked cabinet. The lock to the cabinet was found to be on the top of the cabinet.
- A bottle of Tums with a manufacture's label indicating "keep out of reach of children" in an unlocked medicine cabinet.
- Benadryl ointment with a manufacture's label indicating "if swallowed get medical help or contact poison control right away".

On [REDACTED]/25, room [REDACTED] 0 of the SDCU was unlocked, unattended, and accessible. The following items were located in room [REDACTED]:

- Zinc Oxide Paste with a manufacturer's label indicating, "in case of accidental ingestion, get medical help or contact a poison control center right away".
- An anti-fungal powder with a manufacturer's label indicating "if swallowed, get medical help or contact a poison control center right away".

On [REDACTED]/25, room 213 of the SDCU was unlocked, unattended and accessible. The following items were located in room 213:

- Colgate toothpaste with a manufacturer's label indicating, "if accidentally swallowed get medical help or

82c - Locking Poisonous Materials (continued)

contact a poison control center right away".

- Sparkle fresh toothpaste with a manufacturer's label indicating, "if accidentally swallowed more than is used for brushing, seek medical help or contact a poison control center immediately".
- Roll on antiperspirant with a manufacture's label stating, "if accidentally swallowed get medical help or contact a poison control center right away".

On [REDACTED] 25, at 11:37 AM, the SDCU laundry room door was unlocked, unattended, and accessible. The following items were found in the laundry room:

- Colgate Toothpaste, with a manufacture's label indicating "if swallowed, get medical help or contact poison control right away".
- Denorex Dandruff Shampoo, with a manufacture's label indicating "if swallowed get medial help or contact a poison control center right away".

None of the residents in the SDCU of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/8/2025- The HWC removed Items for room [REDACTED] and properly secured per community policy.

7/8/2025- HWC completed an audit for the resident rooms in SDCU for unsecured poisonous materials. Items were immediately removed.

7/21/2025- ED re-educated the SDCU staff regarding the community policy to keep all poisonous materials properly stored, labeled and locked.

8/11/2025- ED and or designee will audit the SDCU to verify poisonous materials are properly labeled, stored and locked weekly x 4 weeks and monthly x 2 months.

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

Not Implemented [REDACTED] - 09/23/2025)

95 - Furniture and Equipment

9. Requirements

2600.

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

Description of Violation

The toilet in the bathroom of room 128 was not working correctly and was hard to flush. Resident #5, who lives in room 128, stated the toilet has been checked on two occasions, but the toilet was still not flushing.

The sofa in the common area of the Secure Dementia Care Unit (SDCU) had a large tear approximately 24 inches in length, spanning the depth of the seat of the sofa and 3 inches wide.

The love seat in the common area of the SDCU had areas of wear on both seats. There were cracks ranging from 3 inches to 18 inches. Two of these worn areas were open to the fiber filling, measuring approximately 1 1/2 inches by 12 inches.

95 - Furniture and Equipment (continued)

The doors of the public bathrooms across from the offices and therapy gym were heavy to open and slam shut. This poses a hazard to residents with walkers and wheelchairs, who struggle with opening the door when trying to use the bathroom.

Plan of Correction

Accept [redacted] - 08/28/2025)

7/8/2025- Maintenance repaired the toilet in room 128 and fixed the door to the women's bathroom.

7/12/2025- The maintenance manager and marketing manager removed the love seat and the couch in SDCU.

7/21/2025- ED re-educated staff in regards to reporting damaged furniture to a manager.

8/18/2025- Maintenance and or designee will complete weekly audits x 4 weeks and monthly audits x 2 months to verify resident toilets are flushing properly, and also inspect furniture for damage. Damaged furniture will be removed and replaced.

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

Not Implemented [redacted] - 09/23/2025)

103g - Storing Food

10. Requirements

2600.

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

Description of Violation

On 7/9/25, there was unlabeled, undated and unsealed fried chicken, chicken tenders, pulled chicken, sausage and beef liver in the protein freezer.

Plan of Correction

Accept [redacted] - 08/29/2025)

7/9/2025- The unlabeled food was discarded by the Dietary Manager as per community policy.

7/11/2025- The Dietary Manager completed an audit of all food items in the freezer and they were labeled per policy.

7/11/2025- ED re-educated dining and kitchen staff on the importance of properly labeling, dating and storing food.

8/11/2025- The ED and or designee will complete weekly audits x 4 weeks, monthly x 2 months to verify food in the freezer is properly labeled, dated and stored.

103g - Storing Food (continued)

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

Not Implemented [redacted] - 09/23/2025)

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.

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

Description of Violation

On 7/9/25, there was an approximate 1-inch accumulation of lint in the lint trap of the dryer located in the Personal Care laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept [redacted] - 08/28/2025)

7/9/2025- The DHS Surveyor removed the lint from the lint trap of the dryer and the Executive Director disposed of it.

7/11/2025- The Executive Director placed signage in the laundry room to remind staff to remove lint after every laundry load.

7/21/2025- ED completed reeducation to staff on the risks of fire hazards if lint is left in the lint trap.

8/11/2025- The ED and or designee will complete audit weekly x 4 weeks and monthly x 2 months to verify lint has been removed from the lint traps. Audits will be added and documented in the community TELS system.

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

Not Implemented [redacted] - 09/22/2025)

121a - Unobstructed Egress

12. Requirements

2600.

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

Description of Violation

On 7/8/25, at 9:25 AM, the exit door near the wellness office to the center courtyard was blocked with a scale used for residents in wheelchairs and walkers.

On 7/8/25, at 10:00 AM, the exit door at the end of the hall in Personal Care was blocked on the outside with a large cardboard box.

Plan of Correction

Accept [redacted] - 08/28/2025)

7/8/2025- The cardboard box was removed from the end of the hallway in Personal Care by the maintenance manager

121a - Unobstructed Egress (continued)

7/21/2025- ED re-educated staff on safe egress routes.

8/15/2025- The scale was removed from the center courtyard door hallway and relocated by the maintenance manager

8/15/2025- The ED and or designee will conduct weekly audits x 4 weeks and monthly x 2 months to verify safe egress routes throughout the community. Audits will be reviewed and documented in the community TELS system.

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

Not Implemented [redacted] - 09/23/2025)

132c - Fire Drill Records

13. Requirements

2600.

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

Description of Violation

The fire drill records for the fire drills completed on 3/26/25, 4/4/25, 5/30/25, 6/2/25 and 6/25/25 did not include the exit route(s) used, number of residents in the home at the time of the drill, the number of residents who evacuated the home, problems encountered and whether the fire alarm or smoke detector was operative.

The fire drill record for the fire drills on 3/26/25 and 4/4/25 did not include AM or PM for the time of the drill.

Plan of Correction

Accept [redacted] - 08/28/2025)

7/11/2025- The ED reeducated the maintenance director and business office manager on the requirements for fire drill records.

7/25/2025- The executive director properly recorded the fire drill.

8/11/2025- The Maintenance director and or designee will complete monthly audits x 3 months to verify fire drills are completed and documented as per community policy and regulation.

Proposed Overall Completion Date: 11/18/2025

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

Not Implemented [redacted] - 09/23/2025)

141b1 - Annual Medical Evaluation

14. Requirements

2600.

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

141b1 - Annual Medical Evaluation (continued)

Description of Violation

Resident #6's most recent medical evaluation was completed on [REDACTED]/23.

Resident #7's most recent medical evaluation was completed on [REDACTED]/23.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/11/2025- Resident 6 & 7's medical evaluations were completed by the Clinical Specialist and physician.

8/18/2025- The HWD and Clinical Specialist completed a Medical evaluation audit for in house residents. Medical evaluations that were found out of compliance were completed.

8/18/2025- HWD will monitor and update community tracker for resident's annual medical evaluations monthly.

8/18/2025- CLINICAL SPECIALIST retrained HWD in community process and procedure for annual medical evaluation compliance.

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

Not Implemented [REDACTED] - 09/23/2025)

183b - Meds and Syringes Locked

15. 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 7/9/25, at approximately 11:00 AM, a bottle of Tums and Benadryl ointment were unlocked, unattended, and accessible in Resident #8's room. Resident #8 is not able to self-administer medications.

On 7/9/25, at approximately 11:00 AM, a container of Zinc Oxide Paste and Antifungal Powder were unlocked, unattended, and accessible in resident #9's room. Resident #9 is not able to self-administer medications.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/9/2025- Medications were immediately removed from resident rooms and secured per community policy by HWC and Clinical Specialist

8/18/2025- Executive Director retrained clinical and management staff regarding the community policy on storage

183b - Meds and Syringes Locked (continued)

of medications in resident rooms.

8/18/2025 - An audit was completed by the Health & Wellness Director of current residents' rooms to inspect for unlocked, unattended and accessible medications. Any medications that were found were properly stored per community policy.

Ongoing starting 8/18/25- To assist with ongoing compliance, the HWD or designee will conduct audits monthly for three (3) months to verify that medications are stored according to community policy.

The ED or designee will review the results of these audits to verify compliance.

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

Not Implemented [redacted] - 09/23/2025)

183e - Storing Medications

16. 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 7/9/25, resident #10's Oxycodone blister pack had an approximate 3 cm tear on the back of day 13 and an approximate 2 cm tear on the back of day 21. The tears were covered with scotch tape with the pills still inside the bubble pack.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept [redacted] - 08/28/2025)

7/11/2025- Resident # 10's Oxycodone for day #13 and #21 were discarded per community policy by HWC and Clinical Specialist.

7/13/2025- Preferred pharmacy completed a full house medication cart audit.

8/18/25- CLINICAL SPECIALIST retrained medical technicians in proper storage and sanitation of medications. MT's were educated to report to HWD when a medication has been improperly stored.

8/18/2025- HWD or designee will complete medication cart audits weekly to verify medications are being stored correctly.

The ED or designee will review the results of these audits to verify compliance

183e - Storing Medications (continued)

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

Not Implemented [REDACTED] - 09/23/2025)

184b - Labeling OTC/CAM

17. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 7/9/25, a package of Claritin belonging to resident #11 was in the medication cart and was not labeled with the resident's name.

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/11/2025- Resident # 11's Claritin was properly labeled by HWC

7/13/2025- Preferred pharmacy completed a full house medication cart audit.

8/18/2025- CLINICAL SPECIALIST retrained medical technicians on the community policy and procedure for labeling residents OTC medications.

8/18/2025- HWD or designee will complete medication cart audits will be completed weekly to verify OTC medications are labeled correctly.

The ED or designee will review the results of these audits to verify compliance

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

Not Implemented [REDACTED] - 09/23/2025)

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

On 7/9/25, the following discrepancies were observed between resident #6's blood sugar readings on the resident's glucometer and the blood sugar readings documented on the resident's medication administration record (MAR):

- On 6/20/25, at 4:34 PM, the resident's glucometer had a blood sugar reading of 107. However, the resident's MAR had a documented blood sugar reading of 182.
- On 7/4/25, at 7:19 AM, the resident's MAR had a documented blood sugar reading of 107. However, there was no blood sugar reading in the resident's glucometer.

185a - Implement Storage Procedures (continued)

- On 7/6/25, at 6:00 PM, the resident's glucometer had a blood sugar reading of 80. However, the resident's MAR had a documented blood sugar reading of 90.

Resident #6 is prescribed Nitroglycerin tablet 0.4mg as needed for chest pain and Sennosides tablet 8.6mg as needed for constipation. However, on 7/9/25, these medications were not available in the home.

Resident #9 is prescribed Artificial Tears Ophthalmic solution as needed for dry eyes. However, on 7/9/25, these eye drops were not available in the home.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept (█) - 08/28/2025)

7/11/2025- The Clinical specialist reordered the Nitroglycerin tablet 0.4mg for Resident #6 from the pharmacy and were received.

7/11/2025- The Clinical specialist reordered the Artificial Tears Ophthalmic Solutions for Resident #9 from the pharmacy and was received.

7/13/2025- Preferred pharmacy completed a full house medication cart audit.

8/18/2025- The HWD or designee will complete weekly med cart audits to verify availability of prn meds.

8/18/2025-The Clinical specialist (CNS) recalibrated the glucometer to verify the correct date and time. The HWD conducted an audit on other glucometers and the readings were found in compliance.

8/18/2025 -The Clinical specialist retrained the direct clinical staff on the regulation and community policy regarding the process of reordering medications and community policy on glucometer readings and documentation. 08/18/2025 - HWD and or designee will complete weekly audits for two (2) months on glucometer readings to verify correct documentation.

The ED or designee will review the results of these audits to verify compliance.

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

Not Implemented (█) - 09/23/2025)

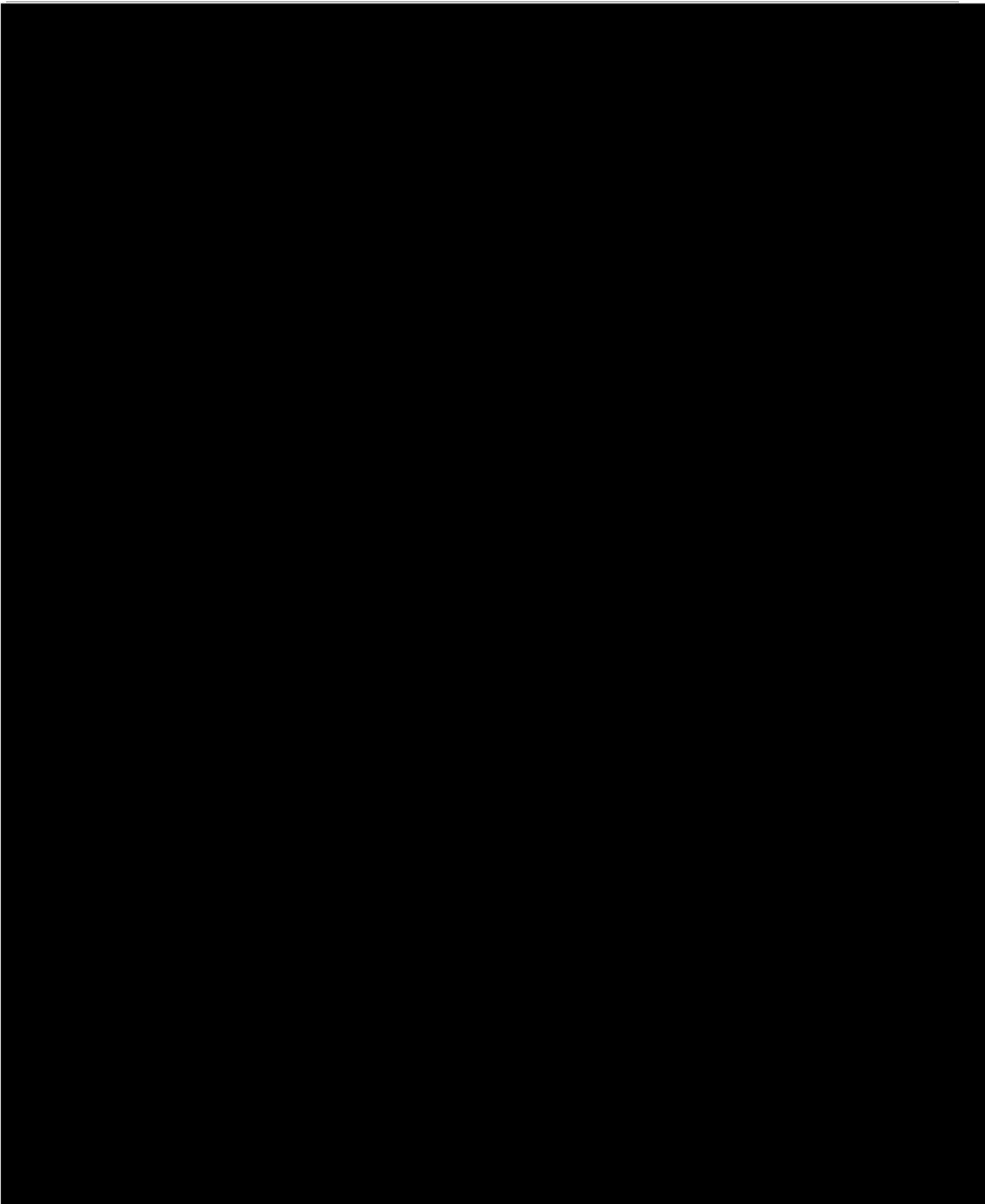
187a - Medication Record

19. Requirements

2600.

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

14. Name and initials of the staff person administering the medication.



187a - Medication Record (*continued*)

187c - Refusal of Medication

20. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 7/2/25, at 8:00 AM, resident #8 refused to take a scheduled dose of Amlodipine Besylate tablet 5mg, Aspirin 81mg, Ferrous Sulfate tablet 325mg and Folic Acid tablet 1 mg. The home did not report these refusals to the prescriber.

On 7/1/25, at 8:00 AM, resident #9 refused to take a scheduled dose of Lasix tablet 40mg and Lisinopril tablet 20mg. The home did not report these refusals to the prescriber.

On 7/1/25, at 9:00 PM, resident #9 refused to take a scheduled dose of Famotidine tablet 20mg. The home did not report this refusal to the prescriber.

On 7/3/25, at 9:00 PM, resident #9 refused to take a scheduled dose of Amlodipine Besylate tablet 5mg and Donepezil HCl tablet 10mg. The home did not report these refusals to the prescriber.

On 7/5/25, at 9:00 PM, resident #9 refused to take a scheduled dose of Amlodipine Besylate tablet 5mg and Donepezil HCl tablet 10mg. The home did not report these refusals to the prescriber.

On 7/6/25, at 9:00 PM, resident #9 refused to take a scheduled dose of Amlodipine Besylate tablet 5mg, Donepezil HCl tablet 10mg, and Famotidine tablet 20mg. The home did not report these refusals to the prescriber.

On 7/7/25, at 8:00 AM, resident #9 refused to take a scheduled dose of Amlodipine Besylate tablet 5mg, Famotidine tablet 20mg, Lasix tablet 40mg, Lisinopril tablet 20mg, multivitamin, Sertraline tablet 100mg, Tylenol 500mg, Atorvastatin Calcium tablet 10mg, Donepezil HCl tablet 10mg, Quetiapine Fumarate tablet 100mg. The home did not report these refusals to the prescriber.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/11/25 Resident # 8 and Resident # 9's refusal of medications on above dates were reported to the physician by the HWD.

8/18/25 -The Clinical Specialist or designee will retrain direct clinical staff on the community policy and procedures regarding resident refusal of medications and reporting to the prescriber within 24 hours.

8/18/25- HWD or Designee will complete weekly audits for two (2) months on the MAR's for resident refusals and compliance to include notifying the prescriber and verify documentation of physician notification.

10/18/25 ongoing- Monthly MAR audits conducted by the Health and Wellness Director or Designee to monitor for resident refusals.

The ED or designee will review the results of these audits to verify compliance.

187c - Refusal of Medication (continued)

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

Not Implemented [redacted] - 09/23/2025)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident #12 is prescribed Dulocolax 5mg tablet with orders to take 1 tablet by mouth one time a day for constipation. However, this medication was not administered on 7/1, 7/2 and 7/3/25 at 8:00 AM due to the medication not being available in the home.

Resident #12 is prescribed Glucosamine-Chondroitin tablet with orders to take 1500mg by mouth one time a day for hemarthrosis in the left knee. However, this medication was not administered on 7/1, 7/2 and 7/3/25 at 8:00 AM due to the medication not being available in the home.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept [redacted] - 08/28/2025)

7/11/2025- Resident # 12's Dulcolax 5mg tablets and Glucosamine- Chondroitin 1500mg was ordered from pharmacy and received into community on 7/14/2025 by HWC.

7/21/2025 - Direct clinical staff will be retrained on the regulation and community policies and procedures regarding following the directions of the prescriber. When medications are not able to be administered as ordered medical technicians and clinical staff must immediately notify the HWD/or designee and prescriber.

7/13/2025- Preferred pharmacy completed a full house medication cart audit to verify medications were available per physician orders.

8/18/2025- To assist with ongoing compliance, the HWD or designee will audit the MAR's weekly for three (3) months to verify that ordered medications are administered to the residents.

The ED or designee will review the results of these audits to verify compliance

187d - Follow Prescriber's Orders (continued)

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

Not Implemented () - 09/23/2025)

190b - Insulin Injections

22. Requirements

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person D has not completed a Department-approved diabetes patient education program. However, on 6/24/25 at 11:30 AM, staff person D administered insulin to resident #6.

Plan of Correction

Accept () - 08/28/2025)

Staff person D was immediately removed from administering insulin until department approved diabetes education program was completed.

7/2/2025-Staff person D completed department approved diabetes education program.

8/18/2025- ED re-educated HWD on the community and state regulation requiring medical technicians to complete a department approved diabetes education program annually.

8/20/2025- Audit was completed by HWC for all medical technicians to verify a department approved diabetes education program has been completed annually.

Ongoing compliance- ED and or designee will audit all newly hired medical technicians (MT) to verify a department approved diabetes education program has been completed prior to MT administering insulin.

[Directed]

- In addition to the steps above, an initial audit of all current medical technician's diabetic education certifications was completed on 8/20/25 and these audits of current medical technician's diabetic education certifications will continue quarterly to ensure compliance by the Executive Director or designee. Documentation of these audits will be kept and will be available for review by the Department.

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

Not Implemented () - 09/23/2025)

225c - Additional Assessment

23. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

225c - Additional Assessment (continued)

Description of Violation

Resident #6's most recent assessment was completed on [REDACTED]/24.

Resident #7's current assessment was completed on [REDACTED]/25. However, the resident's previous assessment was completed on [REDACTED]/23.

Plan of Correction

Accept [REDACTED] - 08/20/2025)

8/18/2025- ED re-educated HWD on community policy and state regulation to complete resident assessments annually.

8/20/2025- HWD and or designee will audit 5 charts weekly for one month, 5 charts monthly for 2 months to verify assessments have been completed annually. Assessments out of compliance will be updated at time of audit.

8/20/25- The HWD will monitor the electronic tracker for completion of assessments monthly

The ED will review the results of these audits to verify if any further action is warranted

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

Not Implemented [REDACTED] - 09/23/2025)

227g -Support Plan Signatures

24. Requirements

2600.

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

Description of Violation

Resident #6's support plan, dated [REDACTED]/24, did not include signature of resident, representative, or person completing the form.

Resident #7's support plan, dated [REDACTED]/25, did not include signature of resident, representative, or person completing the form.

Resident #8's support plan, dated [REDACTED]/25, did not include signature of resident, representative, or person completing the form.

Resident #9's support plan, dated [REDACTED]/25, did not include signature of resident, representative or person completing the form.

227g -Support Plan Signatures (continued)

Plan of Correction

Accept ([REDACTED] - 08/28/2025)

8/15/2025- - Resident #6 , #7, #8, #9's support plan have been signed and dated with date of signature by Clinical Support Specialist

8/18/2025- Executive Director re-educated HWD and CLINICAL SPECIALIST on the community and state regulations for all support plans to be signed by nurse, residents and /or representative.

8/18/2025- HWD and or designee will audit 5 charts weekly for one month, 5 charts monthly for 2 months to verify resident support plans are signed.

The ED will review the results of these audits to verify if any further action is warranted

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

Not Implemented ([REDACTED] - 09/23/2025)

231b - Medical Evaluation

25. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #9 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/25; however, the resident's initial medical evaluation was completed on [REDACTED]/24.

Plan of Correction

Accept ([REDACTED] - 08/28/2025)

7/16/2025- An audit was completed by HWC and Clinical Support Specialist for resident medical evaluations. An electronic tracker was completed to verify compliance. Medical evaluations that were out of compliance were updated.

8/18/2025- ED retrained HWD regarding the community policy for initial medical evaluations being completed within 60 days of admission.

8/18/2025 and ongoing ED and or designee will review residents initial medical evaluations to verify completion within 60 days of admission weekly x 4 weeks and monthly x 2 months.

The ED will review the results of these audits to verify if any further action is warranted

231b - Medical Evaluation (continued)

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

Not Implemented [REDACTED] - 09/23/2025)

231e - No Objection Statement

26. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #8 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/25. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction

Accept [REDACTED] - 08/28/2025)

7/14/2025- The ED retrained the sales manager on the need to have a designated person complete the objections statement prior to admission to the SDCU.

8/15/2025- Audit completed on SDCU resident to verify the objection statement was completed. Resident charts were updated if found out of compliance.

8/11/2025- The HWD and or designee will complete audits for new admissions to memory care unit weekly x 4 weeks and monthly x 2 months to verify the completion of the objection statement prior to admission.

The ED will review the results of these audits to verify if any further action is warranted

8/28/25 - Objections statement signed by [REDACTED] for resident #8

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

Not Implemented [REDACTED] - 09/23/2025)

233c - Key-Locking Devices

27. Requirements

2600.

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

Description of Violation

The directions for operating the home's locking mechanism were not conspicuously posted near the door exiting from the Secure Dementia Care Unit (SDCU) to the courtyard or the gate exiting from the SDCU courtyard.

Repeated Violation - 7/10/24, et al

Plan of Correction

Accept [REDACTED] - 08/20/2025)

7/11/2025- - Executive Director posted the codes on the SDCU exits and entrances by the courtyard.

233c - Key-Locking Devices (continued)

7/21/2025- Management staff were retrained by the ED on the community policy regarding key-locking device signage.

To assist with ongoing compliance, The [redacted] or designee from the SDCU will audit the entrances and exits beginning 8-18- 2025 , weekly for one month and monthly for 2 months to verify door locking codes are posted according to community policy.

ED or designee will review the audit results to verify compliance.

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

Not Implemented ([redacted] - 09/23/2025)

234a - Admission Support Plan

28. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #8 was admitted to the Secure Dementia Care Unit on [redacted]/25. However, the resident's admission support plan was completed on [redacted]/25.

Plan of Correction

Accept ([redacted] - 08/20/2025)

8/18/25 - Audits to be completed on current SDCU resident support plans by the HWD or designee to verify compliance, support plans found out of compliance will be documented on electronic tracker.

8/18/2025- The ED re-educated the HWD on the time frame for completion of the support plans for the SDCU residents.

To assist with ongoing compliance the ED/Designee will review new admissions to the SDCU for 2 months to verify support plan completion within 72 hours of the admission, or within 72 hours prior to the resident's admission.

ED or designee will review the audit results to verify compliance.

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

Implemented ([redacted] - 09/23/2025)

236 - Staff Training

29. Requirements

2600.

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

Description of Violation

Staff person E, hired on [REDACTED]/13, who works in the Secure Dementia Care Unit (SDCU) had only 3 hours of training in dementia care during the 2024 training year.

Staff person F, hired on [REDACTED] 23, who works in the SDCU had only 1 hour of training in dementia care during the 2024 training year.

Plan of Correction

Directed [REDACTED] - 08/28/2025)

7/11/2025- Staff person E and F were re-educated on the need to complete annual training for SDCU, annual training will be complete by 12/31/25

7/21/2025 – The ED re-educated the SDCU staff on the requirements for annual education.

7/15/2025- An audit was completed for the current year to verify annual education is being completed for the SDCU staff.

8/15/2025- The ED and or designee will complete weekly audits x 4 weeks and monthly x 2 months to verify annual training is being completed by SDCU staff.

The ED will review the results of these audits to verify if any further action is warranted

[Directed]

- In addition to the steps above, staff person E will complete the missing 3 hours of dementia-related training from the 2024 training year by 9/12/25. This is in addition to the 6 hours of dementia-related training for the 2025 training year. Documentation of this education will be kept and available for review by the Department.
- Staff person F will complete the missing 5 hours of dementia-related training from the 2024 training year by 9/12/25. This is in addition to the 6 hours of dementia-related training for the 2025 training year. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 09/12/2025

Not Implemented [REDACTED] - 09/23/2025)