pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **2830 CAROL RD OPCO LLC**
LEGAL ENTITY

To operate **AMOROSO WELLNESS AT YORK**
NAME OF FACILITY OR AGENCY

Located at **2830 CAROL ROAD, YORK, PA 17402**
(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 **125** (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 20**

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 **October 24, 2025** until **April 24, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **337791**

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: OCTOBER 24, 2025

[redacted]
2830 Carol Road OPCO LLC
2830 Carol Road
York, PA 17042

RE: Amoroso Wellness at York
2830 Carol Road
York, PA 17402
License/COC #: 337791

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on June 11, 2025, August 5, 2025, August 6, 2025 and August 7, 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 License #33779 dated June 3,2025 through June 3, 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) and 55 Pa. Code § 20.71(a)(2);(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 24, 2025 to April 24, 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 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
23(b)	II	94	$5	$470	5 calendar days from mailing date of this letter
42(b)	II	94	$5	$470	5 calendar days from mailing date of this letter
81(b)	II	94	$5	$470	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 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 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, Pennsylvania 17105-2675
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,

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: *AMOROSO WELLNESS AT YORK* **License #**: *33779* **License Expiration**: *06/03/2026*

Address: *2830 CAROL ROAD, YORK, PA 17402*

County: *YORK* **Region**: *CENTRAL*

Administrator

Name: [redacted]

Legal Entity

Name: *2830 CAROL RD OPCO LLC*

Address: *2830 CAROL ROAD, YORK, PA, 17402*
[redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/07/2022* **Issued By**: *Springettsbury Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *127* **Waking Staff**: *95*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *06/11/2025*

Inspection Dates and Department Representative

06/11/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *93*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Aria* **Capacity**: *20* **Residents Served**: *18*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *93*

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

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

06/11/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2025*

Inspections / Reviews *(continued)*

07/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/18/2025*

07/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/31/2025*

10/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2025*

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

15a - Resident Abuse Report

1. 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]/25 at approximately 9:00 PM, Staff members A and B responded to a yell for help. Resident #1 reported to staff members A and B that resident #2 pushed [redacted] on the ground and smashed [redacted] head into the wall. Resident #1 had a red mark on [redacted] head. This allegation was reported to the home's Administrator and Director of Nursing. However, this allegation of abuse was not reported to the local area agency on aging.

Repeated Violation - 8/6/24, et al.

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

An incident report was written and reported to DHS by Administrator on May 16, 2025 regarding the incident with resident #1 and #2.

An education will be held on July 31, 2025 by DOW to all staff including the Administrator, regarding 15a and the correlation to the violation including the appropriate methods for reporting incidents to the local Area on Aging.

An audit of Incident Reports from March 1, 2025 through July 18, 2025 will be conducted by the Administrator on July 18, 2025 to ensure all incidents have been reported to DHS as well as AAA.

Starting July 18, 2025, DOW or ADON will monitor the home's 24 hour report to capture any incidents or potential incidents. If an incident is captured, the DOW or designee will immediately report to AAA and DHS.

All abuse or potential abuse will be immediately reported to the DOW and Administrator by the Medication Technicians who will add the potential incident reports to the 24 hour report.

All written incident reports will then be given to the Administrator who will ensure reporting to Area on Aging and DHS has been completed within 24 hours.

The DOW or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting on August 29, 2025.

(Directed)
In addition to the above plan of correction:

- *Beginning no later than 7/25/25, all abuse or potential abuse will be immediately reported to the DOW and Administrator by the Medication Technicians who will add the potential incident reports to the 24 hour report. All written incident reports will then be given to the Administrator who will ensure reporting to Area on Aging and DHS has been completed within 24 hours.*

15a - Resident Abuse Report (continued)

- *An Act 13 Mandatory Abuse form will be submitted to the local Area Agency on Aging (AAA) for the incident that occurred on 5/16/25 no later than 7/25/25.*
- *Documentation of completed reports to AAA, audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/31/2025*

Not Implemented ([redacted] - 08/27/2025)

16c - Written Incident Report

2. 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]/25 at approximately 9:00 PM, Staff members A and B responded to a yell for help. Resident #1 reported to staff members A and B that resident #2 pushed [redacted] on the ground and smashed [redacted] head into the wall. Resident #1 had a red mark on [redacted] head. This allegation was reported to the home's Administrator and Director of Nursing. However, this allegation of abuse was not reported to the Department.

Repeated Violation - 2/5/25, 10/8/24, et al.

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

On June 16, 2025 the incident regarding resident #1 to 16c was reported to the Department of Health by the Administrator.

A training regarding 16c will be conducted by the DOW for all staff including the Administrator on July 31, 2025.

DOW or ADOW will monitor the homes 24 hour Point Click Care report to ensure any incidents or potential incidents will be captured and will be reported to the department within the 24 hour reporting window. The 24 hour report monitoring will commence on June 19, 2025 and will occur daily for a period of six weeks.

DOW or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting on August 29, 2025.

(Directed)
In addition to the above plan of correction:

- *A reportable incident document will be submitted to the Department of Human Services by the Administrator no later than 7/31/25.*
- *Documentation of education, daily monitoring of the 24 hour report, and incident reports submitted to the Department will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/31/2025*

16c - Written Incident Report *(continued)*

Implemented (/02/2025)

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

On 5, resident #2 shoved resident #3, resulting in resident #3 falling on back and both residents being placed on 30-minute checks for 14 days, starting on 5/13/25.

On 5/16/25, at approximately 9:00 PM, staff member A heard a loud "help me" coming from resident #1 and #2's shared bedroom. Staff members A and B responded to the bedroom and found resident #1 lying on the ground and resident #2 standing over resident #1. Resident #1 reported to staff members A and B that resident #2 pushed on the ground and smashed head into the wall; a red mark was present on resident #1's head. Staff member C, the home's Administrator, separated residents #1 and #2 into separate bedrooms for a week after the incident until the determination was made to return residents #1 and #2 back into the same bedroom.

On 25, at approximately 7:30 PM, staff member B heard resident #1 ask for help. Upon entry to resident #1's bedroom, staff member B witnessed resident #1 lying on back on the foot of the bed. Resident #2 was sitting on resident #1's bed and had resident #1 in a head lock with the cord from resident #1's hospital bed remote wrapped tightly around resident #1's neck. Resident #2 was hitting resident #1 in the head. Resident #1 was struggling to breath and face was red and swollen with a puffy eye.
Emergency services were contacted by staff members of the home. Residents #1 and #2 were transported and admitted to the hospital on /25. Upon arrival to the hospital, resident #1 was suffering abnormal, very fast atrial fibrillation, required medication immediately upon arrival to control their heart rate and rhythm, and had multiple areas of ecchymosis (bruises) to the face, head and ear. The emergency room indicated the atrial fibrillation was likely due to the stress and trauma provoked from the strangulation suffered at Amoroso. Resident #1 was hospitalized until 25.

Repeated Violation - 2/5/25, 10/8/24,et al., 8/6/24, et al.

Plan of Correction ***Accept - 07/18/2025)***

The incident from May 12-May 16- and June 6 were all reported and submitted to DHS and AAA.
The report from May 16, 2025 was resubmitted to DHS and AAA on July 14, 2025.

Resident #2 was transported to Hospital on June 6, 2025. On June 9, 2025, a 30 day notice was written and mailed. Resident #2 was not allowed to return to the Amoroso Wellness at York.

Resident #3 moved out of the home on approximately , 2025.

A training on 42b by Administrator will be held for all staff at the next two monthly staff meetings on July 31, 2025 and August 28, 2025.

42b - Abuse (continued)

A training will be held by Gentiva Hospice on July 31, 2025 for all staff focusing on positive resident interventions and redirecting techniques.

The DON or designee will perform an audit of all residents behavioral and supervision needs to ensure they are up to date and accurate. This will ensure the home is able to meet the needs of the current residents. This will be completed by July 31, 2025.

The home's Personal Care Policy regarding abuse has been updated on July 16, 2025 by the Administrator to reflect new procedures regarding resident-to-resident abuse and safeguards. Staff will be trained on the updated policy by the Administrator on July 31, 2025.

This will be discussed at our next Quality Assurance meeting on August 29, 2025.

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

Not Implemented ([redacted] - 08/27/2025)

187b - Date/Time of Medication Admin.

4. 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 #1 is prescribed Lorazepam 0.5mg as needed for Anxiety Disorder. Resident #1's May 2025 medication administration record did not include the initials of the staff person who administered Lorazepam on 5/16/25 on between 9:00 PM and 10:30 PM.

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

The MAR regarding resident #1 was corrected on July 8, 2025 by the ADOW.

An education on 187d will be given by Director of Wellness to all Medication Technicians on July 31, 2025.

Starting July 31, 2025 residents #1's MAR and daily narcotic document will be reviewed daily for four weeks by DOW or designee to ensure all medications that have been dispensed will be signed for in a timely manner.

DOW or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting on August 29, 2025.

(Directed)
In addition to the above plan of correction,:

- *All staff who administer medications will receive education on 2600.187(b) by 7/31/25 by the Administrator*

187b - Date/Time of Medication Admin. (continued)

or designee.

- *Documentation of education, and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/31/2025*

Not Implemented (- 08/27/2025)

225c - Additional Assessment

5. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's assessment, dated /24, indicated minimal problems with agitation, irritability, and aggression. However, on 5/21/25 staff reported the following behaviors to the resident's physician and did not update the resident's assessment of need: increased episodes of aggression, swatting at medications in staff's hands, up wandering on 3rd (night) shift, and not sleeping until 5am.

Resident #2's assessment, dated /25, indicated no problems in the following areas: irritability, judgement, agitation, and aggression, However, on /25, resident #2 shoved another resident to the ground resulting in the need for staff to complete checks on resident #2, every 30 minutes for 14 days. The change in supervision needs was never updated in resident #2's assessment. On /25, resident #2 wrapped a cord around resident #1's neck, placed resident #1 in a headlock and continuously hit resident #1 on the head. Resident #2's assessment was never updated to reflect the resident's physical aggression towards others.

Plan of Correction ***Accept - 07/18/2025)***

Resident 1#'s RASP was updated on July 15, 2025 by DOW.
Resident #2 no longer resides at the community, he was discharged on 2025.

On July 16, 2025, Administrator trained Director of Wellness and Assistant Director of Wellness on 225c.

An audit will be completed by DOW or designee for all Memory Care residents RASP's on July 18, 2025.

An audit regarding 225c will be conducted monthly by DOW or designee for two months starting on July 18 and concluding August 18, 2025.

This will be discussed at our next Quality Assurance meeting on August 29, 2025.

Licensee's Proposed Overall Completion Date: *07/18/2025*

Not Implemented - 08/27/2025)

234a - Admission Support Plan

6. 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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/25. However, the resident's initial support plan was completed on [redacted]/25.

Plan of Correction ***Accept[redacted] - 07/14/2025)***

Resident #2 was discharged from the home on [redacted], 2025.

An education by Administrator to DOW and ADON regarding 234a will be held on July 15, 2025.

An audit of all Memory Care Support plans will be conducted on July 18, 2025 by DOW or designee.

Commencing on July 16, 2025 DOW or designee will monitor all new memory care admissions to ensure all support plans are completed within 72 hours of the admission.

DOW or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Control meeting on August 1, 2025.

Licensee's Proposed Overall Completion Date: *07/18/2025*

Not Implemented [redacted] - 08/27/2025)

234d - Support Plan Revision

8. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #1's support plan, completed on [redacted]/24, indicated staff will provide assistance with transfers as needed to rise from or sit/lie on a bed or chair. However, as of 4/3/25, resident #1's physician indicated the resident requires mostly a 2-person assist to be transferred from bed to wheelchair. Resident #1's support plan was never updated to reflect the plan to meet the resident's needs.

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

Resident #1's support plan was updated by DOW on [redacted] 2025.

234d - Support Plan Revision (continued)

An education by Administrator to DOW and ADON regarding 234d will be held on July 16, 2025.

An audit of all resident support plans will be completed by DOW or designee to ensure all all supports are provided based on the needs of the residents. This will be completed by July 31, 2025.

Commencing July 18, 2025 DOW or designee will review all new admissions as well as monitor all current residents support plans monthly for the next two months to ensure ongoing compliance.

DOW or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting held on August 29, 2025.

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

Not Implemented [redacted] 08/27/2025)

251b - Record Entries Legible

9. Requirements

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

Description of Violation

Correction fluid was used on resident #1's medical evaluation, dated 10/3/24.

Correction fluid was used on resident #2's cognitive prescreen, dated 4/25/25.

Plan of Correction ***Accept [redacted] - 07/14/2025)***

Resident # 2 was discharged from the home on [redacted] 2025.

On July 10, 2025, the Administrator collected correction fluid within the home.

On July 18, 2025, DOW performed an audit of all current resident's DME's and Prescreens to ensure the documents are permanent and not altered.

On July 15, 2025, the Administrator held and education for the DOW and ADON regarding 251b and the correlation to the regulation.

Al state documents are given to the receptionist to upload into our computer system. Starting July 14, 2025, receptionist will review all incoming documents prior to uploading into the computer system for a period of four weeks to ensure ongoing compliance.

This will be discussed at our next Quality Assurance meeting on August 1, 2025.

251b - Record Entries Legible (continued)

Licensee's Proposed Overall Completion Date: *07/18/2025*

Implemented [redacted] - 08/27/2025)

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

Facility Information

Name: *AMOROSO WELLNESS AT YORK* **License #:** *33779* **License Expiration:** *06/03/2026*

Address: *2830 CAROL ROAD, YORK, PA 17402*

County: *YORK* **Region:** *CENTRAL*

Administrator

Name: [redacted]

Legal Entity

Name: *2830 CAROL RD OPCO LLC*

Address: *2830 CAROL ROAD, YORK, PA, 17402*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *02/03/2022* **Issued By:** *springettsbury township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *135* **Waking Staff:** *101*

Inspection Information

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

Reason: *Renewal, Complaint, Interim* **Exit Conference Date:** *08/07/2025*

Inspection Dates and Department Representative

08/05/2025 - On-Site: [redacted]
08/06/2025 - On-Site: [redacted]
08/07/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *94*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Aria* **Capacity:** *20* **Residents Served:** *19*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *94*

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

Have Mobility Need: *46* **Have Physical Disability:** *0*

Inspections / Reviews

08/05/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/08/2025*

09/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/19/2025*

09/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/01/2025*

10/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2025*

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 8/5/25, the home's violation reports, dated 4/22/25, 2/5/25, and 10/8/24, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 09/12/2025)***

On August 5, 2025 Administrator added the missing reports from 10/8/24, 2/5/25, and 4/22/25 to the binder in the lobby.

On August 5 2025, Administrator educated self on 3C and the correlation to the violation.
Starting September 15, 2025, Administrator will audit POC binder weekly for four weeks to ensure all POC's from the past year are in the binder. If any are missing they will be replaced the same day.

Administrator will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented [redacted] - 10/02/2025)

16c - Written Incident Report

2. 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

Resident #2 resides in the home's Secured Dementia Care Unit (SDCU). The resident's assessment, dated [redacted]/25, indicated the resident's need for extensive supervision in the home . The resident cannot leave the home unattended, is unaware of unsafe areas and needs someone with [redacted] when outside the community. Resident #1's progress note, dated [redacted]25, indicated a late entry for an incident where resident #2 was found unsupervised, in the home's parking lot. Staff member C was notified of this incident by staff member B. The home did not report this incident to the Department.

Repeated Violation - 5/29/25, et al., 2/5/25, 10/8/24, et al.

16c - Written Incident Report *(continued)*

Plan of Correction ***Accept [redacted] 09/12/2025)***

The incident report regarding resident # 2 was submitted to the DHS on [redacted]8/2025 by the Administrator.

An education was held by Administrator to the DON and ADON on 9/9/2025 regarding 16c and the correlation to the violation.

The Administrator will perform an audit on 9/15/2025 of all Incident Reports from June 2025 until present to ensure all have been reported within 24 hours.

Starting on July 18, 2025, ADON has been review the 24 hour report daily to ensure the community does not allow a reportable incident to go unreported. This will continue daily until November 1, 2025.

The DON will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented ([redacted] - 10/02/2025)

23b - Instrumental Activities of Daily Living Assistance

3. Requirements

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

Description of Violation

Resident #2 resides in the home's Secured Dementia Care Unit (SDCU). The resident's assessment, dated [redacted]/25, indicated the resident's need for extensive supervision in the home . The resident cannot leave the home unattended, is unaware of unsafe areas and needs someone with[redacted] when outside the community. [redacted] requires regular supervision in the home. Resident #1's progress note, dated [redacted]/25, indicated a late entry for an incident where resident #2 was found unsupervised, in the home's parking lot by a staff member who was leaving for the evening around 10:30 PM.

Repeated Violation - 8/6/24, et al.

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

Resident #2 was immediately brought back into the SDCU by a staff member on [redacted]/2025.

An education by DON will be held on 9/25/2025 to all nursing staff regarding 23b and the correlation to the violation.

On 9/11/2025 ADON updated the care plan to reflect [redacted] exit seeking. DON did assess to ensure the home is capable of meeting the needs of the resident and and captured that in the care plan.

Starting 8/10/2025 resident #2 was placed on 15 min checks for all shifts to ensure resident safety. On 8/18/2025

23b - Instrumental Activities of Daily Living Assistance (continued)

these checks were changed by DOW to 30 min checks to continue indefinitely. These checks were put in place due to the resident exiting the SDCU unit on 8/10/2025.
Since the check were implemented, resident has not left the SDCU.

DOW or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Not Implemented [redacted] - 10/02/2025)

42s - Privacy

4. 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

The home has video cameras that record in common areas including common TV areas on the ground floor, second floor, Secured Dementia Care Unit and the main lobby.

Repeated Violation - 8/6/24, et al.

Plan of Correction ***Accept ([redacted] 09/22/2025)***

The cameras on the ground floor second floor and SDCU were removed on 9/8/2025 by Maintenance Manager.
A camera remains in the front lobby area pointed at the front entrance. A sign stating recording of the lobby is in progress is posted in the lobby.

An education was held by Administrator to Maintenance Manger on 9/8/2025 regarding 42s and the correlation to the violation.
Starting 9/22/2025, the Maintenance Manager or designee will walk the interior of the community quarterly to ensure no camera's have been installed. This will continue for a period of one year.

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/22/2025*

Implemented [redacted] - 10/02/2025)

51 - Criminal Background Check

5. Requirements

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

Description of Violation

Staff member F, hired on [redacted]25, did not have Pennsylvania criminal history background check requested until [redacted]/28/25.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Staff member F is no longer employed at the community as of [redacted]/2025.

An education was held by Administrator to Executive Assistant on 8/15/2025 regarding 51 and the correlation to the violation.

An audit on 9/19/2025 by Executive Assistant of all staff for the month of June, July and August will be conducted to ensure all new hires have a completed background check. If a current staff is found not to have a background check, that particular staff will be immediately removed from the schedule until a cleared check has been obtained.

Starting 9/16/2025, all new hire background checks will be conducted prior to the new hire's first day. A checklist will be kept for all new hires, when the background check was conducted and their initial start date for a period of four weeks.

Starting 9/22/2025 the Administrator will review checklist on a weekly basis to ensure regulatory compliance.

Executive Assistant will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/22/2025*

Not Implemented [redacted] - 10/02/2025)

81b - Resident Personal Equipment

6. 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 8/6/25 at 12:00 PM, resident #1's bed was affixed with a bed cane that when grasped, moved approximately 4-5 inches away from the mattress creating a potential hazard for entrapment and falls.

On 8/6/25 at 11:49 AM, resident #7's enabler bar slid under the resident's mattress and was not securely attached to the structure of the bed. The uncovered opening to the device measured 13 inches by 20 inches, posing a potential hazard for entrapment.

81b - Resident Personal Equipment (continued)

On 8/6/25, at 11:54 AM, resident #8's bed cane slid under the resident's mattress and was not securely attached to the structure of the bed posing a potential hazard for entrapment and falls.

Repeated Violation - 8/6/24, et al.

Plan of Correction ***Accept [redacted] - 09/12/2025)***

On 8/8/2025, Maintenance Manager secured the cane on resident #1 bed, changed resident #7's halo to a bed cane and secured it to the frame, and secured resident #8's cane to the frame of the bed.

An education was held by Administrator to Maintenance Manager on 9/8/2025 regarding 81b and the correlation to the violation.

Starting 9/19/2025, maintenance will ensure all in house bed canes are secured on a weekly basis for a period of four weeks.

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/19/2025*

Not Implemented [redacted] - 10/02/2025)

85e - Trash Outside Home

7. 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 8/5/25 at 9:49 AM, the exterior garbage can was overflowing with trash which was propping open the lid to the receptable. The garbage can was not actively in use at the time of the inspection.

Plan of Correction ***Accept [redacted] 09/12/2025)***

The trash can in question was dumped on 8/5/2025 by Maintenance.

An education was held by Administrator to the Maintenance Manager on 9/8/2025 regarding 85e and the correlation to the violation.

Starting 9/15/2025, Maintenance will check the trash cans in the rear of the building daily for a period of four weeks to ensure all lids are closed, covering the trash at all times.

Maintenance Manager will be responsible for ongoing compliance.

85e - Trash Outside Home (continued)

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented [redacted] - 10/02/2025)

103c - Food Protected

8. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 8/5/24 at approximately 9:25 AM, 2 small bowls containing a creamy food item were stored in the Secured Dementia Care Unit's refrigerator uncovered and unprotected from contamination. A meal was not being served at the time of the inspection.

Plan of Correction ***Accept [redacted] - 09/12/2025)***

The food in question was immediately removed from the refrigerator and discarded on 8/5/2025 by the Medication Technician.

An education by the Dietary Manager will be held on 9/25/2025 for all Dietary staff regarding 103c and the correlation to the violation.

Starting 9/29/2025, a daily check by Dietary staff of the SDCU refrigerator to ensure all food items are covered and dated commencing for a period of four weeks.

The Dietary Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Implemented [redacted] - 10/02/2025)

107c - Food/Water 3 Day Supply

9. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 8/5/25, the home served 89 residents, requiring 267 gallons of emergency drinking water. However, the home had only 155 gallons. The home does not have a contract with a local bottled water supplier that includes immediate delivery of drinking water.

107c - Food/Water 3 Day Supply *(continued)*

Plan of Correction ***Accept [redacted] - 09/12/2025)***

492 gallons of water was delivered to the community on 8/7/2025. This supply would support 160 residents.

An education was held on 9/8/2025 by the Administrator to the Dietary Manger regarding 107c and the correlation to the violation.

Starting on 9/15/2025, the Dietary Manager will count the water supply and ensure it is within date on a monthly basis for a period of three months.

The Dietary Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented [redacted] 10/02/2025)

132b - Safety Inspection/Fire Drill

10. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection completed by a fire safety expert was conducted on 3/15/24.

Plan of Correction ***Accept [redacted] - 09/12/2025)***

An updated fire safety inspection was conducted on 8/8/2025 by [redacted].

An education by Administrator was held on 9/8/2025 to the Maintenance Manager regarding 132b and the correlation to the violation.

Maintenance Manager is aware of the annual inspection and has already scheduled for July of 2026.
The home utilizes TELS which will also alert a reminder two months prior to due date.

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented [redacted] - 10/02/2025)

132c - Fire Drill Records

11. Requirements

2600.

132c - Fire Drill Records *(continued)*

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 monthly fire drill records for August 2024 through July 2025, did not include the number of residents evacuated as only the residents closest to the staged fire area were accounted for in the documentation.

A fire drill was held on 7/30/25; however, direct care staff members were aware of the scheduled fire drill and started the evacuation process prior to the fire alarm sounding. This fire drill and problems encountered were not documented in the home's July 2025 fire drill record.

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

On 8/8/2025, the Maintenance Manager revised the fire drill document and corrected all previous drills for 2025 to reflect the number of all in-house residents who were actually evacuated.

The drill on 7/30/2025 was added to the fire drill record including the problems incurred. by the Maintenance Manager on 8/8/2025.

An education was held on 9/8/2025 by Administrator to the Maintenance Manager regarding 132c and the correlation to the violation.

Starting September 30h of 2025, the Administrator will review all fire drill evacuation documentation and initial after every drill to ensure all elements are being captured. This will commence throughout the remainder of 2025.

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at out next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] 10/02/2025)

132d - Evacuation

12. 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

The home did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- *On 7/31/25, evacuation time was 8 minutes and 52 seconds.*
- *On 6/27/25, evacuation time was 8 minutes and 34 seconds.*

132d - Evacuation (continued)

- *On 5/27/25, evacuation time was 9 minutes and 38 seconds.*
- *On 4/3/25, evacuation time was 8 minutes and 24 seconds.*
- *On 3/3/25, evacuation time was 14 minutes and 58 seconds.*
- *On 2/11/25, evacuation time was 14 minutes and 15 seconds.*
- *On 1/24/25, evacuation time was 14 minutes and 42 seconds.*

Plan of Correction ***Accept (- 09/22/2025)***

A fire safety expert will be visiting the community on 9/15/2025. The safety expert will be conducting a site visit and witnessing a drill.
The home is requesting an extended evacuation from the fire safety expert.

An education by the Administrator to the Maintenance Manager on 9/16/2025 regarding 132d and the correlation to the violation.

Starting in October 2025, the Administrator will review each fire drill to determine the success of the drill. If the drill was unsuccessful for any reason, another drill will be conducted during the same month. ***(Directed) The administrator will begin monthly reviews of each fire drill no later than 10/1/25-***

After monthly drills, the Maintenance Manager will hold a meeting to discuss the drill success or failure with all participating staff.
This will commence with the September 2025 drill. ***(Directed) monthly meetings to discuss the fire drills will begin no later than 9/30/25-*** *During the "after drill" meetings, all barriers are discussed as well as to better prepare for the next drill.*

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Proposed Overall Completion Date: 09/15/2025

Licensee's Proposed Overall Completion Date: *10/01/2025*

Implemented - 10/02/2025)

132h - Designated Meeting Place

13. 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

Multiple staff and resident interviews indicated resident #9 does not participate in any monthly fire drills conducted in the home.

Plan of Correction ***Directed (- 09/22/2025)***

On 15/2025 a 30 day notice will be issued to resident #9 as their care can no longer be managed by the home. An MA-51 has been completed on resident #9.

132h - Designated Meeting Place (continued)

An education by Administrator to Maintenance Manager was held on 9/8/2025 regarding 132h and the correlation to the violation. An education to all staff regarding resident 9 and the broda chair will be held by Administrator on 9/25/2025.

DON will update resident #9 support plan on 9/19/2025 to reflect the broda chair and the support she will need to evacuate.

Resident #9 is currently on hospice care. Hospice brought a broda chair in to transfer the resident from bed to the chair during drills until discharge.

The fire evacuation accountability documents will be reviewed by the Maintenance Manager no more than two days post drill to ensure all residents including resident #9 evacuated. This will start in October 2025 and continue indefinitely.

This will be discussed at our next Quality Assurance meeting.

(Directed)
In addition to the above plan of correction:

- *All staff and residents in the home will receive education on the requirement for resident participation during monthly fire drills. education will be completed by 9/30/25. Documentation of resident and staff education will be kept by the home and available for review by the Department.*
- *Fire evacuation accountability documents will be reviewed by Maintenance Manager no more than two days post drill to ensure all residents, including resident #9, evacuated. This will begin no later than 10/1/25.*

Directed Completion Date: *10/01/2025*

Not Implemented ([redacted] - 10/02/2025)

141b1 - Annual Medical Evaluation

15. Requirements

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

Description of Violation

Resident #2's status change medical evaluation, completed [redacted]/25, did not include a list of the resident's medications. ***Repeat violation: 5/29/25***

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

Resident #2 medication list was added to his DME on 8/7/2025 by DON.

An education will be held by Administrator to DON and ADON on 9/19/2025 regarding 141b1 and the correlation to the violation. The education will include 2600.141.a.2 1-10.

An audit of all resident DME's will be conducted by DON or designee the week of 9/22/2025 to ensure all DME's have a complete medication list.

Starting 9/22/2025, DON will review all new admissions and annual resident DME's to ensure each one includes a

141b1 - Annual Medical Evaluation (continued)

medication list. This will run for a period of four weeks.

Administrator will review for accuracy.
Within a five day period after initial completion, DON and Administrator will review for accuracy,

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/22/2025*

Not Implemented [redacted] - 10/02/2025)

144b - Policy on Smoking

16. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The smoking policy outlined in the resident handbook indicated, as of 6/1/11 the campus is smoke free and all staff, residents, family members, and visitors are not permitted to smoke anywhere on the campus; however, the home established a designated smoking area in the lower parking lot for staff members which is not identified in the home's smoking policy.

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

The smoking policy as well as the Resident Handbook was amended by the Administrator on 8/28/2025 to reflect smoking on the property in a designated area for staff only.

Administrator reviewed 144b on 9/10/2025 and the correlation to the violation.
On 9/25/2025 Staff meeting, the Administrator will review the new smoking policy with all staff.

Administrator will conduct a policy review once a month 9/29/2025 and 10/29/2025 to ensure compliance.

The Administrator will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/02/2025)

144c1 - Smoking Area Guidelines

17. Requirements

2600.

144c1 - Smoking Area Guidelines *(continued)*

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is the lower parking lot by a picnic table. However, on 8/5/25, 2 cigarette butts were in the stairwell outside the ground west hall exit, and a staff member was vaping on the walkway outside by the memory care area during the physical site inspection.

Repeated Violation - 8/6/24, et al.

Plan of Correction ***Accept ([redacted] - 09/12/2025)***

All cigarette butts were removed on 8/5/2025. A sweep of the exterior perimeter of the building was conducted by a member of the Maintenance team on 8/5/2025 to ensure no other cigarette butts were found.

The staff member who was vaping in close proximity of the building was reminded of the smoking policy and the only designated area on 8/5/ 2025.

An education will be held by the Administrator to all staff on 9/25/2025 regarding 144c1 and the correlation to the violation. A copy of the smoking policy will be distributed to all staff during the training.

Starting 9/19/2025, Maintenance staff will inspect the exterior of the building for any evidence of smoking on a weekly basis for a period of four weeks.

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Not Implemented[redacted] - 10/02/2025)

171b5 - First Aid Kit

18. 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

The first aid kit in the 2022 Dodge Ram van, used to transport residents, did not include a thermometer, scissors, eye mask, and breathing shield.

Plan of Correction ***Accept [redacted] 09/22/2025)***

Two first aid kits which contains all supplies listed in 171b5 was obtained on 8/14/2025 and placed in the 2022

171b5 - First Aid Kit (continued)

Dodge Ram as well as the Ford by the Maintenance Manager on 8/14/2025.

An education was held by Administrator on 9/8/2025 for the Maintenance Manager regarding 171b5 and the correlation to the violation.

Starting the week of 9/22/2025, the Maintenance Manager or designee will inspect both vans weekly for a period of four weeks to ensure the first aid kit is in the vehicle and is complete.

The Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/22/2025*

Implemented [redacted] 10/02/2025)

182b - Prescription Medication

19. 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.
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

Resident #15 is not able to self-administer medications and is prescribed Enoxaparin 60mg/.6ml injection subcutaneously once every 24 hours. Staff interviews indicated the home does not always staff medically licensed personnel to administer the medication; therefore, the resident's family comes into the home on some weekends to administer the medication to the resident.

Plan of Correction ***Accept [redacted] 09/22/2025)***

Resident #15 will be issued a 30 day notice to on [redacted]5/2025 as [redacted] care can no longer be managed at the home. Outside of insulin injections, resident #15 is the only current resident requiring an injection.

An education by Administrator will be held on 9/18/2025 with DON and ADON regarding 182b and the correlation to the violation.
In the interim, DON will perform the daily injections including weekends for resident 15 until resident has been discharged from the community.
The DON is the only staff member who qualified to give the injections.

182b - Prescription Medication (continued)

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/22/2025*

Not Implemented [redacted] - 10/02/2025)

182c - Medication Administration

20. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 8/6/25 at 1:47 PM and 1:48 PM, staff member H documented the administration of resident #19's prescribed Lorazepam 0.5mg and hydrazine 25mg. However, staff member H had both medications in a plastic medication cup in the medication area at 1:48 PM. Staff member H documented the administration of a medication prior to giving the medication to resident #19.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

An education will be held by DON to all Medication Technicians on 9/25/2025 regarding 182c and the correlation to the violation.

Starting 9/29/2025 DON or designee will conduct three medication observations per week including multiple Medication Technicians and shifts to ensure medications are being distributed per regulations. This will occur for a period of four weeks.
Three different Medication Technicians will be observed weekly.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/02/2025)

183e - Storing Medications

21. 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 8/7/25, a used Novolog Flexpen belonging to resident #12 was in the home's medication cart and not labeled with the date it was opened.

On 8/7/25, resident #13's Rocklatan Opth Soln 2.5ml eye drops were in the home's medication cart; however, the eye drops expired 5/2025.

On 8/7/25, an unopened bottle of Rocklatan Opth Soln 2.5ml, prescribed for resident #13, was stored in the home's medication cart; however, instructions from the pharmacy indicated to refrigerate until open.

Repeated Violation - 8/6/24, et al.

Plan of Correction ***Accept [redacted] - 09/12/2025)***

Resident #12 pen was discarded by DON on 8/7/2025 and a new one opened and dated on the same date.

Resident #13 eye drops were discarded by DON on 8/7/2025. the bottle of Rocklatan Opth Soln was discarded by DON on 8/7/2025 and another was ordered via pharmacy the same day.

An education will be held by DON to all Medication Technicians on 9/25/2025 regarding 183e and the correlation to the violation.

Starting 9/29/2025 monthly medication cart audits will be completed by DON or designee to ensure compliance with 183e. This will commence for a period of four months.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/02/2025)

184a - Resident's Meds Labeled

22. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
2. The name of the medication.
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #10 is prescribed Acetaminophen 325mg, take 2 tablets by mouth twice daily as needed, max 3000mg/24

184a - Resident's Meds Labeled (continued)

hrs. However, the pharmacy label indicated, take 2 tablets by mouth every 4 hours as needed for mild pain or temp greater than 101.

Repeated Violation - 10/8/24, et al.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Resident #10 DON placed a change or direction label on the medication on 8/7/2025 which alerts staff to follow directions on the MAR not the label.

An education by DON to all Medication Technicians will be held on 9/25/2025 regarding 184a and the correlation to the violation.

Starting the week of 9/30/2025 DON or designee will audit all resident orders and compare to the pharmacy label. This audit should be complete by 10/3/2025.

Starting 9/29/2025, medication cart audits will be completed by DON or designee monthly for a period of four months to ensure compliance with 184a. Medication cart audits consist of, Removing all outdated medications, matching orders to the resident's MAR, count of all narcotic medications, dates on opened medications including insulin pens, ensuring al powders, syrup's and eye drops are in date, search for loose pills, write new orders if needed, and reorder any medications.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] 10/02/2025)

185a - Implement Storage Procedures

23. 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 #16 is prescribed Milk of Magnesia, take as needed every 2 hours if no bowel movement in 3 days. On 8/6/25, this medication was not available at the home.

185a - Implement Storage Procedures (continued)

Resident #18's glucometer measured a blood glucose reading of 141 on 8/1/25 at 4:34 PM; however, the blood glucose reading is not documented in the resident's August 2025 Medication Administration Record.

Repeated Violation - 10/8/24, et al.

Plan of Correction ***Directed [redacted] - 09/22/2025)***

A box in the MAR was added for resident #11 by DON for the Medication Technicians to record blood pressure and heart rate on 8/7/2025.

Resident #16 milk of Magnesia was ordered by DON on 8/7/2025 and arrived at the facility on 8/7/2025.

Resident #18 glucose reading of 141 on 8/1/2025 was recorded in the MAR on 9/9/2025 by DON.

An education by DON to all Medication Technicians on 9/25/2025 regarding 185a and the correlation to the violation. During this meeting, the Medication technicians will be given a small notebook to record their glucose readings. They will then take the correct reading they scribed in the notebook and submit that recorded number in the correct corresponding resident MAR. This will ensure an accurate glucometer reading recorded into the MAR.

Starting the week of 9/29/2025 monthly medication cart audits will be performed for a period of four months to ensure compliance with 185a. Medication cart audits consist of, Removing all outdated medications, matching orders to the resident's MAR, count of all narcotic medications, dates on opened medications including insulin pens, ensuring al powders, syrup's and eye drops are in date, search for loose pills, write new orders if needed, and reorder any medications.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

(Directed)

- *Beginning no later than 9/30/25, the Administrator or designee will complete weekly audits on resident glucometers to ensure the blood glucose level in the glucometer matches the blood glucose level documented in the resident's record. Documentation of completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] - 10/03/2025)

187a - Medication Record

24. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
2. Drug allergies.
8. Frequency of administration.

187a - Medication Record *(continued)*

Description of Violation

Resident #10 is prescribed Acetaminophen 325mg, take 2 tablets by mouth twice daily as needed, max 3000mg/24 hrs. However, the resident's August 2025 Medication Administration Record (MAR) indicated, give 2 tabs orally as needed for pain.

Resident #17 has drug allergies to Ciprofloxacin, Aspirin, and Levofloxacin as indicated on the resident's medical evaluation, dated 3/4/25. Resident #17's August 2025 MAR indicated "No Known Allergies"

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Resident #10 DON placed a change of direction label on the medication on 8/7/2025 to alert Medication Technicians to follow the orders on the MAR not the label. The MAR was also updated on 8/7/2025.

Resident #17 DON added the allergies to the MAR on 8/7/2025.

An education will be held by DON to all Medication Technicians on 9/25/2025 regarding 187a and the correlation to the violation.

Starting the week of 9/29/2025 medication cart audits will be conducted monthly by DON or designee for a period of four months to ensure compliance with 187a. Medication cart audits consist of, Removing all outdated medications, matching orders to the resident's MAR, count of all narcotic medications, dates on opened medications including insulin pens, ensuring al powders, syrup's and eye drops are in date, search for loose pills, write new orders if needed, and reorder any medications.

Starting 9/29/2025, DON or designee will review 5 MAR's per week and compare to the actual label on the medication to ensure they match. If they don't match, a change of direction label will be placed on the medication and the pharmacy will be contacted. This review will continue for a period of four weeks.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented ([redacted] - 10/03/2025)

187b - Date/Time of Medication Admin.

25. 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

On 8/6/25 at 8:00 AM, staff member H administered Lorazepam 1mg to resident #2; however, staff member H did not record the administration on the resident's Medication Administration Record (MAR) until 2:01 PM.

On 8/6/25 at 8:00 AM, staff member H administered Lorazepam to resident #16; however, staff member H did not

187b - Date/Time of Medication Admin. (continued)

record the administration on the resident's MAR until 1:44 PM.

Plan of Correction ***Accept [redacted] 09/22/2025)***

An education by DON to all Medication Technicians will be held on 9/25/2025 regarding 187b and the correlation to the violation.

Staff member H will be re-educated on 182c as well as 187b by DON or ADON on 9/25/2025.

Starting 9/29/2025 DON or designee will conduct three medication observations per week including multiple Medication Technicians and shifts to ensure medications are being distributed per regulations. This will occur for a period of four weeks.
Three Medication Technicians will be observed weekly.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented ([redacted] - 10/03/2025)

187c - Refusal of Medication

26. 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

Resident #17 refused the following, scheduled medications and treatments; the prescriber was not notified:

- *From 8/1/25 through 8/5/25 at 7:00 AM-Ammonium Lactate lotion, apply to bilateral legs and feet once daily for dry skin.*
- *On 8/3/25 and 8/5/25 at 7:00 AM-Mupirocin 2% ointment, apply topically to affected toes twice daily for wound healing.*
- *On 8/1/25, 8/3/25, and 8/5/25 at 3:00 PM-Mupirocin 2% ointment, apply topically to affected toes twice daily for wound healing.*
- *On 8/3/25 and 8/5/25 at 7:00 AM-Sodium Chloride 9%, cleanse bilateral great toes with wound cleanser, cover and secure with bordered gauze*

Plan of Correction ***Accept [redacted] - 09/22/2025)***

On 9/10/2025 resident #17 PCP was faxed [redacted] refusals, medications and dates by ADON.

An education by DON to all Medication Technicians will be held on 9/25/2025 regarding 187c and the correlation to the violation.

187c - Refusal of Medication (continued)

The week of 9/22/2025 ADON will audit resident #17 MAR for the past three months to ensure any refusals are reported to PCP. Audit should be completed by 9/25/2025.

Starting 9/29/2025, ADON or designee will audit resident #17 MAR every other day for a period of four weeks to ensure all medication refusals are reported to PCP within 24 hours.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/03/2025)

187d - Follow Prescriber's Orders

27. Requirements

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

Description of Violation

Resident #3 is prescribed Ensure original vanilla supplement drink to be administered with meals. However, resident #3 was not administered ensure original vanilla supplement drink with lunch on 8/5/25.

On 7/25/25, resident #3 was prescribed, Fluorometholone .1% eye drop suspension, instill one drop into both eyes three times daily for one week, then once daily for one week. Staff administered the medication 3 times daily from 7/26/25-8/2/25; however, the next dose was not administered until 9:00 AM on 8/5/25.

On 7/30/25, resident #4 was prescribed Mupirocin 2% ointment, apply to wounds on legs three times daily for 10 days. The medication was only applied twice daily on 8/1/25 and 8/5/25 at 9:00 AM and 5:00 PM. On 8/7/25, this medication was not administered at 9:00 AM as the medication was not available in the home.

Resident #18 is prescribed Insulin Aspart, inject 7 units subcutaneously 3 times daily before breakfast, lunch and dinner. On 8/7/25, this medication was not administered until after resident #18 ate lunch.

Repeated Violation - 10/8/24, et al, 8/6/24, et al.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Resident 3 ensure resumed at dinnertime on 8/5/2025 by Medication Technician.
Resident 4 medication was ordered by Medication Technician on 8/7/2025 and received in the home the same day.
Resident 18 per prescribers orders the injections resumed at dinnertime on 8/7/2025.

An education by DON to all Medication Technicians will be held on 9/25/2025 regarding 187d and the correlation to the violation.

187d - Follow Prescriber's Orders (continued)

Ensuring medications will be available in the home is through the monthly cart audits. The auditor will ensure any medication which needs reordering will be completed at the time of the cart audit. cart audits consist of, removing all outdated medications, matching orders to the resident's MAR, count of all narcotic medications, dates on opened medications including insulin pens, ensuring al powders, syrup's and eye drops are in date, search for loose pills, write new orders if needed, and reorder any medications. ***(Directed) Monthly medication cart audits will be completed by the Administrator or designee beginning no later than 9/29/25-***[redacted]

Starting the week of 9/29/2025 MAR audits will be performed by DON or designee on resident 3, 4, and 18 daily, for a period of four weeks to ensure ongoing compliance. Resident #18's MAR has been flagged to remind all Medication Technicians of the three times daily injections prior to all meals. DON will also place reminder card in the medication cart to ensure the Medication technicians follow prescribers orders.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented ([redacted] - 10/03/2025)

225a - Assessment 15 Days

28. Requirements

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

Description of Violation

Resident #17 is diagnosed with Ambulatory Dysfunction and Diabetes for which the resident receives daily insulin injections. The resident's assessment, dated [redacted]*25, did not include these medical diagnoses.*

Resident #20's bed is affixed with a bed cane; however, the resident's assessment, dated [redacted]*/25, indicated the resident is able to turn and position self in bed/chair and does not include description of service need for the use of a bedside mobility device.*

Plan of Correction ***Accept*** [redacted] ***- 09/22/2025)***

Resident 17 diagnosis was added to their assessment on [redacted]*/2025 by DON.*
Resident 20 adaptive device was added to their assessment on [redacted]*/2025 by DON.*

An education by Administrator to DON and ADON will be held on 9/18/2025 regarding 225a and the correlation to the violation.

An audit of all resident assessments by DON will begin the week of 9/22/2025 to ensure all diagnosis and adaptive equipment are captured.. This audit should be completed by 10/3/2025.

225a - Assessment 15 Days (continued)

Starting the week of 9/22/2025, DON will review all new admission and updated assessments to ensure they diagnosis and all adaptive equipment has been captured on the assessment. The DON will be reviewing within 7 days of initial completion. If this is an SDCU admission, DON will review within 24 hours following completion.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/22/2025*

Not Implemented [redacted] - 10/03/2025)

225c - Additional Assessment

29. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #17 was evaluated and treated in the emergency room on [redacted]/25 due to abdominal pain. The resident was diagnosed with a subacute t12 compression fracture and biliary duct dilation. The resident's assessment, dated [redacted]/25, was not updated to reflect these changes.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Resident 17 compression fracture and biliary duct dilation was added to [redacted] assessment on [redacted]/2025 by DON.

An education by Administrator to DON and ADON will be held on 9/18/2025 regarding 225c and the correlation to the violation.

Starting the week of 9/22/2025 an audit of all assessments will be performed by DON to ensure all diagnosis are captured. This review will be completed by 10/3/2025.

Starting the week of 9/29/2025 DON will review all reported resident assessment changes on a weekly basis for a period of four weeks to ensure regulatory compliance.

DON will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/03/2025)

227d - Support Plan Medical/Dental

30. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #7's bed is affixed with an enabler bar; however, the resident's support plan, dated [redacted]/25, does not include the intended use of the device, any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, or whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] 09/22/2025)***

On 8/7/2025 Maintenance Manager changed resident 7's enabler bar to a bed cane and secured to the bed frame. The bed cane was added to resident 7"s RASP on 9/11/2025 by ADON including the rationale. The update did include the intended use, risks associated, and the residents ability to use the device.

An education by Administrator to DON and ADON will be held on 9/18/2025 regarding 227d and the correlation to the violation.

DON will audit all residents support plan who use a bed cane the week of 9/22/2025 to ensure the cane has been added to all plans including the rationale. This audit will be completed by 10/3/2025.

Starting 9/29/2025, DON or designee will review all future residents who receive a bed cane support plan to ensure the intended use, risks associated, as well as the residents ability to use the bed cane. This will continue for a period of four weeks.

DON will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/03/2025)

227e - Self Administer Medication

31. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #7's assessment, completed [redacted]/25, indicated the resident cannot self-administer medications; however, their support plan, completed [redacted]/25, does not address the support provided to the resident in the area of medication administration.

227e - Self Administer Medication *(continued)*

Plan of Correction ***Accept [redacted] - 09/22/2025)***

On 9/6/2025, DON updated resident 7's support plan.

An education by Administrator to DON and ADON will be held on 9/18/2025 regarding 227e and the correlation to the violation.

The week of 9/22/2025, DON will audit all residents RASP's to ensure proper support regarding medication administration has been documented. Completion date is 10/3/2025.

Starting 9/29/2025, DON will review all new admissions and annuals to ensure medication supports are documented. DON will review 7 days after completion. If the resident is a new admission to the SDCU, DON will review within 24 hours.

DON will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/03/2025)

231c - Preadmission Screening

32. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #11 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/25. However, the resident #11's written cognitive preadmission screening was completed on 7/9/25.

Repeated Violation - 5/29/25 ,et al.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

An education will be held by Administrator to DOW and ADON on 9/9/2025 regarding 231c and the correlation to the violation.

An audit will be conducted by ADON the week of 9/15/2025 to ensure all current SDCU residents prescreens are within 72 hours of admission. This will be completed by 9/19/2025.

Starting 9/19/2025 Administrator will review all preadmission screens for new admissions to the SDCU for a period of four weeks to ensure compliance.

DON will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

231c - Preadmission Screening (continued)

Licensee's Proposed Overall Completion Date: *09/22/2025*

Not Implemented [redacted] - 10/03/2025)

233a - Lock Approval

33. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic lock on the egress gate located in the Secured Dementia Care Unit courtyard.

Plan of Correction ***Accept ([redacted] - 09/12/2025)***

On 8/8/2025, a Township Code and Compliance Officer inspected the locks in our SDCU to ensure all three magnetic locks are functioning for emergency egress. The letter states all three locks are functioning properly.

An education was held by the Administrator to the Maintenance Manager on 9/8/2025 regarding 233a and the correlation to the violation.

In the future, if a SDCU magnetic lock has to be repaired or changed, the Maintenance Manager will ask the Township Compliance Officer to re-inspect the locks for compliance.

Maintenance Manager will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/08/2025*

Implemented ([redacted] - 10/03/2025)

234a - Admission Support Plan

34. 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 #10 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/25. However, the resident's initial support plan was completed on [redacted]3/25.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Resident 10 was moved to the PC side of the community on [redacted]/2025.

234a - Admission Support Plan (continued)

An education by Administrator to DON and ADON will be held on 9/18/2025 regarding 234a and the correlation to the violation.

An audit by DON will be performed on all SDCU support plans to ensure they are compliant. This audit will take place the week of 9/22/2025 and be completed by 10/3/2025.

Starting 9/29/2025 DON will review all new SDCU admissions for a period of four weeks to ensure resident support plan completion within 72 hours. Administrator will review after DON to ensure compliance.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/03/2025)

234b - Support Plan Needs Elements

35. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #10's assessment and support plan, dated [redacted]25, does not address the resident's diagnosis of Depression or need for daily medication management and staff support in this area.

Resident #11's assessment and support plan, dated [redacted]/25, indicated the resident is prescribed a regular diet; however, the resident has been prescribed a bite-size, level 6 diet due to dysphagia since [redacted]/25.

Resident #11's assessment and support plan, dated [redacted]5, does not include the following diagnoses: Dysphagia, Depression, Atrial Fibrillation, Chronic Respiratory Failure, or Macular Degeneration,. Resident #11is prescribed oxygen as needed, physical therapy and occupational therapy due to their [redacted] which is not documented in the resident's assessment and support plan.

Resident #16's assessment and support plan, dated [redacted]/25, indicated the resident is prescribed a regular diet of 3 meals per day. However, on 2/26/25, resident #16 was prescribed a mechanical soft texture diet, thin consistency, and finger foods.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Resident 10's depression was added to support plan by DON on 9/9/2025.
Resident 11's new diet and diagnoses of Dysphagia, Depression, Atrial Fibrillation, CRF and Macular Degeneration, oxygen as needed, PT/OT were added to the support plan by DON on 9/9/2025. Resident 16's mechanical soft texture diet, thin consistency, and finger foods were added to the support plan by DON on 9/9/2025.

An education by Administrator to DON and ADON will be held on 9/18/2025 regarding 234b and the correlation to the violation.

234b - Support Plan Needs Elements (continued)

Starting the week of 9/22/2025, DON will be reviewing all resident RASP's to ensure all resident's physical, medical, social, cognitive, and safety needs are captured and up to date. The audit will be completed by 10/3/2025.

Starting the week of 9/29/2025 DON will review all completed new admission and annual RASP's to ensure all elements of 234b are included. This will continue or a period of four weeks.

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented (- 10/03/2025)

234d - Support Plan Revision

36. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #4's assessment and support plan, dated /25, indicated the resident is independently mobile but needs moderate oral assistance to evacuate in an emergency; however, the resident is totally immobile and requires total staff assistance to propel a wheelchair throughout the facility and in emergencies.

Resident #4's bed was equipped with a bed cane. However, the resident's support plan, dated /25, does not include: the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended.

Plan of Correction ***Accept (- 09/22/2025)***

Resident 4 correct mobility status and the need for a bed cane was added to the support plan by DON on 2025.

An education by Administrator to DON and ADON was held on 9/18/2025 regarding 234d and the correlation to the violation.

The week of 9/22/2025, DON will be auditing all resident RASP's to ensure they contain the correct adaptive equipment and accurate mobility needs. Furthermore, DON will be ensuring the need for the device and any associated risks. Completion date is 10/3/2025.

Starting 9/29/2025, DON will review all new and annual RASP's to ensure compliance with 234d weekly for a period of six weeks.

234d - Support Plan Revision (continued)

DON or designee will be responsible for ongoing compliance.

This will be discussed at our next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *09/29/2025*

Not Implemented [redacted] - 10/03/2025)