

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

July 9, 2025

[REDACTED], PRESIDENT/COO
GRAINGER AID OPCO LLC
[REDACTED]

RE: ALLEGHENY PLACE
10960 FRANKSTOWN ROAD
PENN HILLS, PA, 15235
LICENSE/COC#: 44489

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: ALLEGHENY PLACE License #: 44489 License Expiration: 04/14/2026
 Address: 10960 FRANKSTOWN ROAD, PENN HILLS, PA 15235
 County: ALLEGHENY Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: GRAINGER AID OPCO LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 02/02/1998 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 52 Waking Staff: 39

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint Exit Conference Date: 05/21/2025

Inspection Dates and Department Representative

05/21/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 47 Residents Served: 42

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 42
 Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 10 Have Physical Disability: 2

Inspections / Reviews

05/21/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/07/2025

06/10/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 07/01/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/16/2025

Inspections / Reviews *(continued)*

06/17/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 07/01/2025

07/09/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

25a - Written Contract and Review

1. Requirements

2600.

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

Description of Violation

Resident #2's resident-home contract, dated [REDACTED] indicates the contract is between the home's legal entity and "resident #1" and "resident #2 if applicable" and does not include resident #2's name.

Resident #4's resident-home contract, dated [REDACTED], indicates the contract is between the home's legal entity and "resident #1" and "resident #2 if applicable" and does not include resident #4's name.

Plan of Correction

Accept ([REDACTED] - 06/16/2025)

- 1) Upon completion of survey, Executive Director immediately contacted Discovery Management Legal department requesting the change in the Residency Agreement.
- 2) Legal provided attachment #1 on 6/6/25, which has an electronic ability to enter Resident's name. This page of the Residency Agreement will be put in use with the next new lease signing, which happens to be 6/6/25. (Attachment #47).
- 3) Every lease thereafter will utilize this version with the requested change in order to remain in compliance with this request.
- 4) ED will provide this new page with resident's names as an addition to their current contract. This shall be completed by close of business 6/20/25. ED will then upload attachment #48 as proof of completion audit.
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/09/2025)

63a - First Aid/CPR Training

2. 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

Daily from 5/4/25 through 5/17/25, there was no staff person present in the home who was trained in first aid during the 10:00pm through 6:00am shift. During these dates, there were approximately 40 residents in the home.

On numerous dates, to include the following dates, there was no staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR during the 10:00pm through 6:00am shift:

63a - First Aid/CPR Training (continued)

- From 5/15/25 at approximately 10:00pm through 5/16/25 at approximately 6:00am
- From 5/14/25 at approximately 10:00pm through 5/15/25 at approximately 6:00am
- From 5/8/25 at approximately 10:00pm through 5/9/25 at approximately 6:00am
- From 5/7/25 at approximately 10:00pm through 5/8/25 at approximately 6:00am

During these dates, there were approximately 40 residents in the home.

Plan of Correction**Directed (█ - 06/16/2025)**

- 1) Upon completion of survey, Executive Director confirmed that employee █ was working on the night shifts dated 5/7, 5/8, 5/14 and 5/15 (schedule is attachment #2) and █ is in fact certified in CPR through 2026. (copy of CPR card is attachment #3) In addition, staff person █ took first-aid training on 6/14/25 and card is attachment #50.
- 2) Current CPR list is attachment #4 which indicates every LPN and Medtech (which supervise every shift 24 hrs / 7 days a week) in this community have current CPR and first-aid verification.
- 3) Additional CPR/First-Aid class was held on June 10th (attachment #51). We are also awaiting a future date in July for an additional class.
- 3) Director of Health and Wellness (DHW) to maintain "tickler" on expiring CPR cards and schedule renewal classes accordingly. (DIRECTED: The tracking system shall be completed by 6/20/25. Documentation of the tracking system shall be kept. █ 6/16/25).
- 4) Executive Director to audit CPR binder on 06/10/2025 and monthly thereafter to ensure we remain in compliance with 2600.63.a. (audit sheet, which confirms all staff certified in CPR and first-aid is attachment #52)

(DIRECTED; Beginning on 6/20/25: The administrator/designee shall review the home's direct care staffing schedule daily to ensure compliance with 2600.63a. █ 6/16/25).

- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented (█ - 07/09/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

65b - Rights/Abuse 40 Hours (continued)

4. Reporting of reportable incidents and conditions.

Description of Violation

Ancillary staff person A, hired on [redacted] did not receive orientation on any of the topics specified in 2600.65b.

Direct care staff person B, hired on [redacted] did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction

Directed ([redacted] - 06/16/2025)

1) Upon return to the community, Executive Director unable to locate orientation / training sheets for staff person "A" or staff person "B". Between 05/22/25 and 06/05/25, all orientation training redone for all employees. These are attachments #6 and #7. (DIRECTED: Documentation of the staff education, including the staff education for staff persons A and B, shall be kept in accordance with 2600.65i. [redacted] 6/16/25).

2) Executive Director and DHW together went through all required orientation trainings for each employee during the time of May 22 - June 05. Any trainings that were missing were completed during this time. Executive Director presently waiting for Orientation checklist form to be produced by corporate so that [redacted] can complete them for files that do not have. Executive Director hoping to have this completed by month's end 6/30. (DIRECTED: Beginning on 6/30/25: The administrator shall implement the new hire checklist to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65b within 40 scheduled working hours. The completed new hire checklists shall be kept in each staff person's record. All staff persons responsible for hiring new employees shall be educated by the administrator on the new checklist by 6/30/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/16/25).

3) Longterm plan effective immediately: No employee will even be added to any working schedule until ED or DHW confirms that all training have been done and ED has signed copy of orientation form in their file to remain in compliance with 2600.65.b.

4) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:

- reportable incidents
- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented ([redacted] - 07/09/2025)

65c - Ancillary Staff Orientation

4. Requirements

2600.

65c - Ancillary Staff Orientation (continued)

65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person A, hired on [REDACTED] did not receive a general orientation to their specific job functions as it relates to their position.

Plan of Correction

Directed ([REDACTED] - 06/16/2025)

- 1) Staff person received [REDACTED] general orientation on 5/20/24 by fellow housekeeper as documented on "Housekeeper Task Sheet" when [REDACTED] was hired. This is attachment #8.
- 2) Moving forward, all employees to complete orientation checklist for their specific position within first day and first 40 hours of training. Executive Director was unaware of these specific forms, but once [REDACTED] receives them from corporate, [REDACTED] will complete one for all employees, hopefully by 6/30/25.
- 3) ED will adapt forms in the future (starting July 1st) for all positions in the community and place them in employee's files to remain in compliance with 2600.65.c.
(DIRECTED: Beginning on 6/30/25: The administrator shall implement the new hire checklist to ensure all ancillary staff persons receive a general orientation to their specific job functions as it relates to their position prior to working in that capacity. The completed new hire checklists shall be kept in each ancillary staff person's record. All staff persons responsible for hiring new employees shall be educated by the administrator on the new checklist by 6/30/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/16/25).
- 4) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/09/2025)

65e - 12 Hours Annual Training

5. Requirements

2600.

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

Description of Violation

Direct care staff person C, hired on [REDACTED], only received approximately 3 hours of annual training during the 2024 training year.

Direct care staff person D, hired on [REDACTED] only received 2 hours of annual training during the 2024 training year.

Plan of Correction

Directed ([REDACTED] - 06/16/2025)

- 1) Upon return to the community, Executive Director unable to locate 2024 training documentation for staff persons "C" and "D". Between 05/22/25 and 06/05/25, all 12 annual trainings done for both employees. These are attachments #9 and #10. (DIRECTED: Documentation of staff person C and D's trainings shall be kept in

65e - 12 Hours Annual Training (continued)

accordance with 2600.65i. [REDACTED] 6/16/25).

2) Knowing that we cannot go backwards and officially complete 2024 trainings, all employees were instructed to immediately complete all available trainings for 2025. Executive Director has access to confirm that all trainings have been done electronically and records will be kept electronically in accordance with 2600.65i.

3) Director of Health & Wellness responsible to make sure all employees do trainings by last day of month or they will be removed from the schedule until they are completed. This will be the procedure moving forward and will begin [REDACTED] monitoring July 1st.

(DIRECTED: Beginning on 7/1/25: The administrator/designee shall review all staff training records monthly to ensure all direct care staff persons receive at least 12 hours of annual training each training year in accordance with 2600.65e. [REDACTED] 6/16/25).

4) Executive Director to monitor all staff trainings for completion monthly moving forward beginning with July trainings to remain in compliance with 2600.65.e. This monitoring will be on a quarterly basis.

5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:

- reportable incidents
- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented [REDACTED] - 07/09/2025)

65f - Training Topics**6. Requirements**

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics (continued)

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

Description of Violation

Direct care staff person C, hired on [REDACTED] did not receive training on any of the topics specified in 2600.65f during the 2024 training year.

Direct care staff person D, hired on [REDACTED] did not receive training on any of the topics specified in 2600.65f during the 2024 training year.

Plan of Correction

Directed ([REDACTED] - 06/16/2025)

- 1) Upon return to the community, Executive Director unable to locate 2024 training documentation for staff persons "C" and "D". Between 05/22/25 and 06/05/25, all annual trainings done for both employees. These are attachments #9 and #10. (DIRECTED: Documentation of staff person C and D's trainings shall be kept in accordance with 2600.65i. [REDACTED] 6/16/25).
- 2) Knowing that we cannot go backwards and officially complete 2024 trainings, all employees were instructed to immediately complete all available trainings for 2025. Executive Director has access and can confirm that these training records are not only completed up through June, but there are too many to upload. Records are maintained electronically and will be kept in accordance with 2600.65i.
- 3) Director of Health & Wellness responsible to make sure all employees do trainings by last day of month or they will be removed from the schedule until they are completed. This will be the procedure moving forward and beginning July 1st or with the start of a new employee beforehand.
- 4) Executive Director to monitor all staff trainings for completion monthly moving forward beginning with July trainings to remain in compliance with 2600.65.f. (DIRECTED: The executive director monthly audits shall begin on 7/1/25. [REDACTED] 6/16/25).

DIRECTED: By 6/30/25: The home shall conduct a quality management review which shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 6/16/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented ([REDACTED] - 07/09/2025)

65g - Annual Training Content

7. 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:
 - 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
 - 3. Resident rights.
 - 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
 - 5. Falls and accident prevention.

65g - Annual Training Content (continued)

Description of Violation

Direct care staff person C, hired on [REDACTED] did not receive training on the following topics during the 2024 training year:

- Emergency preparedness procedures and recognition and response to crises and emergency situations
- Resident rights
- The Older Adult Protective Services Act
- Falls and accident prevention

Direct care staff person D, hired on [REDACTED] did not receive training on the following topics during the 2024 training year:

- Emergency preparedness procedures and recognition and response to crises and emergency situations
- Resident rights
- The Older Adult Protective Services Act
- Falls and accident prevention

Plan of Correction

Directed ([REDACTED] - 06/16/2025)

- 1) Upon return to the community, Executive Director unable to locate 2024 training documentation for staff persons "C" and "D". Between 05/22/25 and 06/05/25, all annual trainings done for both employees. These are attachments #9 and #10. (DIRECTED: Documentation of staff person C and D's trainings shall be kept in accordance with 2600.65i. [REDACTED] 6/16/25).
- 2) Knowing that we cannot go backwards and officially complete 2024 trainings, all employees were instructed to immediately complete all available trainings for 2025. Executive Director has access and can confirm that these training records are not only completed up through June, but there are too many to upload. Records to be kept in accordance with 2600.65i.
- 3) Director of Health & Wellness responsible to make sure all employees do trainings by last day of month or they will be removed from the schedule until they are completed. This will be the procedure moving forward.
- 4) Executive Director to monitor all staff trainings for completion monthly moving forward beginning with July trainings to remain in compliance with 2600.65.g. (DIRECTED: The executive director monthly audits shall begin on 7/1/25. [REDACTED] 6/16/25).

DIRECTED: By 6/30/25: The home shall conduct a quality management review which shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 6/16/25

Proposed Overall Completion Date: 07/31/2025

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented ([REDACTED] - 07/09/2025)

85d - Trash Receptacles

8. Requirements

2600.

85d - Trash Receptacles (continued)

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 10:15am, there was an uncovered trash can, which was approximately 1/2 full of trash, in the common staff bathroom located next to bedroom #101.

Plan of Correction

Directed ([redacted]) - 06/16/2025

- 1) During this survey with Inspector present, trash was immediately removed from common bathroom and receptacle was replaced with one having an attached lid. (attachment #11).
- 2) Upon entrance to building next day, Executive Director conducted an audit of all bathroom and kitchen areas to ensure trash receptacles had lids present, which they did.
- 3) Housekeeping, again made aware on 5/22 of receptacle requirements and will ensure compliance with 2600.85.d via daily housekeeping task sheet. (attachment #8)
- 4) Executive Director will audit monthly beginning July 1, 25 to ensure that compliance remains. (DIRECTED: The monthly audits shall include a check of all bathrooms and kitchens to ensure compliance with 2600.85d. [redacted] 6/16/25)
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented ([redacted]) - 07/09/2025

85e - Trash Outside Home

9. 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

At approximately 10:30am, the side door to the home's dumpster was open. At the time of inspection, the dumpster was approximately 1/4 full of trash.

Plan of Correction

Directed ([redacted]) - 06/16/2025

During walk-through at inspection on 5/21, the dumpster doors were closed by staff.

85e - Trash Outside Home (continued)

- 1) Staff meeting held on 05/30/2025 and one of the discussed topics was requirement of dumpster doors remaining closed. (attachment of meeting agenda #14 and sign-n sheet #15A&B) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [REDACTED] 6/16/25).
- 2) Signs placed around dumpster (on 5/22 when ED returned to the community) stating that doors must remain closed. (attachment #16)
- 3) Kitchen staff notified (at all staff meeting on 5/30/25) to monitor every day the dumpster to ensure doors are kept closed. This monitoring to begin 05/30/25.
- 4) Executive Director to ensure we remain in compliance with 2600.85.e by monitoring area twice daily during walking rounds. These rounds are effective 5/22/25 upon ED return.
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/09/2025)

121a - Unobstructed Egress**10. 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

At 10:25am, a folding chair, a 5 gallon bucket, and a container of unknown cooking oil were present on the walkway directly outside the emergency exit door near the employee break room, blocking this egress route.

Plan of Correction

Directed ([REDACTED] - 06/16/2025)

All items removed by staff during inspection.

- 1) During all-staff meeting, one of the topics discussed was the blocking of egress routes. (attachments #14 and #15A&B)
- 2) Beginning 5/30/25, Kitchen staff to monitor this particular area daily for obstacles, as staff uses this area during their breaks.
- 3) Signs also posted on 5/22/25 (when ED returned to the community) by all exit doors as to not blocking egress routes. (attachment #17)
- 4) Executive Director to monitor these areas during daily walking rounds to ensure we remain in compliance with

121a - Unobstructed Egress (continued)

2600.121.a. Walking rounds to begin 5/22/25. (DIRECTED; The executive director shall inspect the entire home daily to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. ■ 6/16/25).

5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:

- reportable incidents
- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

DIRECTED: By 6/30/25: The administrator shall ensure all current staff persons are re-educated that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of the staff education shall be kept in accordance with 2600.65i. ■ 6/16/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented (■ - 07/09/2025)

132a - Monthly Fire Drill**11. Requirements**

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home has not conducted an unannounced fire drill since 1/30/25.

Plan of Correction

Directed (■ - 06/16/2025)

1) Fire Drills were conducted monthly as required, however the home was unable to produce paperwork due to change in personnel. Moving forward...

2) On 06/6/2025, an unannounced monthly fire drill was conducted by the home as required. (attachment #18 and #19)

3) Home is presently recruiting for a Director of Maintenance. This is the person typically responsible for conducting fire drills, but until this happens, fire drills will be conducted monthly by Director of Health & Wellness, who was trained on community procedures upon ■ hire 04/28/25 to remain in compliance with 2600.132.a.

4) Executive Director will monitor monthly beginning June first to ensure this happens. (DIRECTED: Beginning on 6/20/25: The administrator shall review all fire drill documentation monthly to ensure an unannounced fire drill is conducted at least monthly in accordance with 2600.132a. ■ 6/16/25).

5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:

- reportable incidents
- complaint procedures
- staff training
- violations received and POC progress / adherence

132a - Monthly Fire Drill (continued)

- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented (█) - 07/09/2025)

132c - Fire Drill Records**12. 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 home's fire drill record for the fire drill conducted on 1/30/25 at 1:43pm does not include the following:

- The specific exit routes used. The most recent documentation by a fire safety expert, dated 7/16/24, indicates numerous fire-safe areas are present in the home. The fire drill record indicates "evac to safe area behind fire doors"; however, it does not indicate the specific fire safe areas used
- The number of residents present in the home at the time of the fire drill

Plan of Correction

Directed (█) - 06/16/2025)

1) Fire Drills were conducted monthly as required, however the home was unable to produce paperwork due to change in personnel. Moving forward...

2) On 06/6/2025, an unannounced monthly fire drill was conducted by the home as required. (attachment #18 and #19)

3) Home is presently recruiting for a Director of Maintenance. This is the person typically responsible for conducting fire drills, but until this happens, fire drills will be conducted monthly by substitute personnel (Director of Health & Wellness, who was trained by Fire Marshall) to remain in compliance with 2600.132.c.

4) Executive Director will monitor monthly beginning with the current drill being done in June 2025 to ensure this happens. (DIRECTED: Beginning on 6/20/25: The administrator shall review all fire drill documentation monthly to ensure fire drill documentation includes all items specified in 2600.132.c. █ 6/16/25).

5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:

- reportable incidents
- complaint procedures
- staff training

132c - Fire Drill Records (continued)

- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented (█ - 07/09/2025)

141a - Medical Evaluation**13. Requirements**

2600.

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

Description of Violation

No medical evaluation was completed for resident #2, who was admitted to the home on █

Plan of Correction

Directed (█ - 06/16/2025)

- 1) Upon return to the community, DHW was able to print out the electronic medical evaluation form for resident #2 dated █ (attachment #22).
- 2) DHW to ensure all admitting DME forms are printed and available to see in medical file within State guidelines. Complete DME audit done the week of May 12-16. (Attachment #25).
- 3) Executive Director to audit each new resident file (beginning with next new admission, which is 6/6/25) and then upon every admission to ensure medical evaluation is completed, signed and available to ensure we remain in compliance with 2600.141.a. .
- 4) Once community switches to complete electronic files in June 2025, all Med-Techs, LPNs and Administration staff will be given access to print records, which will allow surveyors to view records upon request.
(DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 6/16/25).
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

141a - Medical Evaluation (continued)

DIRECTED: By 7/1/25: The administrator shall develop and implement a new admission checklist to ensure timely completion of resident medical evaluations in accordance with 2600.141a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated by the administrator on the new checklist by 7/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/17/25).

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented ([REDACTED] - 07/09/2025)

141b1 - Annual Medical Evaluation

14. Requirements

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [REDACTED] however, resident #1's previous medical evaluation was completed on [REDACTED]

Resident #3's most recent medical evaluation was completed on [REDACTED]; however, resident #3's previous medical evaluation was completed on [REDACTED].

REPEAT VIOLATION: 10/1/2024

Plan of Correction

Directed ([REDACTED] - 06/16/2025)

- 1) Upon return to the community, DHW was able to print out the electronic medical evaluation form for resident #1 dated 06/02/24 (attachment #23) and the medical evaluation form for resident #3 dated //24 (attachment #24).*
- 2) DHW to ensure all annual DME forms are printed and available to see in medical file within State guidelines. Complete DME audit done the week of May 12-16. (Attachment #25)*
- 3) Executive Director to randomly audit 5 resident files quarterly to ensure annual medical evaluations are completed, signed and available to ensure we remain in compliance with 2600.141.b.1. These audits to begin in July. (DIRECTED: The quarterly audits shall begin on 7/1/25. [REDACTED] 6/16/25).*
- 4) Once community switches to complete electronic files in June 2025, all Med-Techs, LPNs and Administration staff will be given access to print records, which will allow surveyors to view records upon request. (DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/16/25).*
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
- reportable incidents*

141b1 - Annual Medical Evaluation (continued)

- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented (█) - 07/09/2025)

183e - Storing Medications**15. 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

At the time of inspection, resident #1's Latanoprost-0.005% eye drops were opened and undated in the medication cart. According to the manufacturer's instructions, the eye drops must be used within 6 weeks of opening. According to resident #1's pharmacy label, the eye drops were delivered to the home on 3/11/25.

At the time of inspection, resident #4's Aspart and Basaglar insulin pens were opened and undated in the medication cart. According to the manufacturer's instructions for Aspart and Basaglar, insulin must be used within 28 days of opening.

REPEAT VIOLATION: 11/2/2023

Plan of Correction

Directed (█) - 06/17/2025)

- 1) Upon arrival to the community on 5/22, DHW discarded all eye drops and insulins for residents #1 and #4, ordered new, dated and initialed them since they would have been out of compliance according to 3/11 date. (New shown in attachments #12 and #13).
- 2) DHW completed audit of both medication carts on 5/26/25 for "date open stickers" (attachment #26).
- 3) Meeting held on 5/28 by DHW with MedTech's and LPNs to discuss proper procedures. (attachments #27 and #28) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. █ 6/17/25).
- 4) Weekly cart audits by DHW to begin June 11th to ensure dated sticker procedure being followed. (DIRECTED: The audits shall include a weekly review of all resident medications to ensure compliance with 2600.183e. █ 6/17/25).
- 5) ED to perform random quarterly audits of both carts (approximately 5 residents total) beginning July 1st to ensure we remain in compliance with 2600.183.e.
- 6) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents

183e - Storing Medications (continued)

- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented (█ - 07/09/2025)

184a - Resident's Meds Labeled**16. Requirements**

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

No pharmacy label was present on resident #3's Veltassa-8.4g, which was present in the medication room refrigerator.

Plan of Correction

Directed (█ - 06/17/2025)

- 1) *Upon return to the building, DHW called pharmacy to notify them that resident #3's Veltassa had no pharmacy label attached to it. Pharmacy delivered a new label on their next evening run 5/22/25. It was applied upon delivery. (attachment #29)*
- 2) *DHW completed audit of both medication carts on 5/26/25 for any medications without labels. (attachment #26).*
- 3) *Meeting held by DHW on 5/28 with MedTech's and LPNs to discuss proper procedures. (attachments #27 and #28) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. █ 6/17/25).*
- 4) *Weekly cart /refrigerator audits by DHW to begin June 11th to ensure proper pharmacy labels are present on all meds.*
(DIRECTED: Beginning on 6/20/25: The administrator/designee shall review the medications and pharmacy labels for at least 6 different residents monthly to ensure compliance with 2600.184a. █ 6/17/25).
- 5) *ED to perform random quarterly audits of both carts (approximately 5 residents total) beginning July 1st to ensure we remain in compliance with 2600.184.a.*
- 6) *Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:*

184a - Resident's Meds Labeled (continued)

- reportable incidents
- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented (█ - 07/09/2025)

185a - Implement Storage Procedures**17. 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 #3 is prescribed Amoxicillin-500mg-Take 4 capsules (2,000mg) by mouth as needed 1 hour before dental appointments; however, this medication was not present and available in the home at time of inspection.

Plan of Correction

Directed (█ - 06/17/2025)

- 1) Upon return to the building, DHW called pharmacy to notify them that resident #3's Amoxicillin Rx needed filled immediately. Pharmacy delivered a new bottle on their next evening run 5/22. (attachment #30)
- 2) DHW completed audit of both medication carts on 5/26/25 for any missing medications (attachment #26).
- 3) Meeting held by DHW on 5/28 with MedTech's and LPNs to discuss proper procedures. (attachments #27 and #28) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. █ 6/17/25).
- 4) Weekly cart /refrigerator audits by DHW to begin June 11th to ensure all ordered medications are present and available for dispensing.
(DIRECTED: Beginning on 6/20/25: The administrator/designee shall review the medications for at least 6 different residents monthly to ensure all prescribed medications are present in the home and to ensure compliance with 2600.185a. █ 6/17/25).
- 5) ED to perform random quarterly audits of both carts (approximately 5 residents total) beginning July 1st to ensure we remain in compliance with 2600.185.a.
- 6) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:

185a - Implement Storage Procedures (continued)

- reportable incidents
- complaint procedures
- staff training
- violations received and POC progress / adherence
- resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented (█) - 07/09/2025)

187b - Date/Time of Medication Admin.**18. 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's May 2025 medication administration record (MAR) does not include the initials of the staff person who administered the following medications to resident #1 on 5/4/25:

- *Dorzolamide 2% solution, which was not documented as administered at 2:00pm*
- *Pilocarpine 1% solution, which was not documented as administered at 2:00pm*

Resident #2's May 2025 MAR does not include the initials of the staff person who administered the following medications to resident #2 on 5/4/25:

- *Aspirin-81mg, which was not documented as administered at 8:30am*
- *Bumetanide-0.5mg, which was not documented as administered at 8:30am*
- *Diclofenac-50mg, which was not documented as administered at 8:30am*

Resident #3's May 2025 MAR does not include the initials of the staff person who administered the following medications to resident #3 on 5/4/25:

- *Amlodipine-10mg, which was not documented as administered at 8:00am*
- *Carvedilol-12.5mg, which was not documented as administered at 8:00am*
- *Pantoprazole-40mg, which was not documented as administered at 7:00am*

Resident #4's May 2025 MAR does not include the initials of the staff person who administered the following medications to resident #4 on 5/4/25:

- *Aspart Insulin, which was not documented as administered at 11:30am and 4:30pm*

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

REPEAT VIOLATION: 11/2/2023

Plan of Correction

Directed (█) - 06/17/2025

Due to a brief power surge, these MARS were not electronically signed. In the case of a power outage, staff is aware of the usage of paper MARS which are initialed and given to DHW for chart placement. This process is discussed during their initial medication training by DHW.

- 1) Upon return to the building, DHW printed out all four of these MARS and had staff document that meds were administered. (Attachments 31-34)
- 2) DHW then went through the electronic MARS for May 4th to ensure no other documentation had been missed, of which there were no more.
- 3) Meeting held on 5/28 by DHW with MedTech's and LPNs to discuss proper procedures for documentation, although staff unable to go backwards in electronic MAR. DHW must be involved for this process. (attachments #27 and #28) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. █ 6/17/25).
- 4) Five weekly MAR audits by DHW to begin June 11th to ensure proper documentation at all times and particularly as a result of power or internet issue.
- 5) ED to perform random quarterly audits of both MAR laptops (approximately 5 residents total) beginning July 1st to ensure we remain in compliance with 2600.187.b.
- 6) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented (█) - 07/09/2025

187d - Follow Prescriber's Orders

19. Requirements

2600.

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

187d - Follow Prescriber's Orders (continued)

Description of Violation

Resident #2 is currently prescribed Cyanocobalam Injection-1,000mcg-Inject 1,000mcg intramuscularly every month on the 1st; however, this medication was not administered to resident #2 on 5/1/25.

Plan of Correction

Directed (█ - 06/17/2025)

- 1) Upon return to the building, DHW called resident #2's physician to notify █ that resident had not received B-12 on 5/1/25, so we would need an order to give it another day. Physician responded that █ had discontinued that medication and would send the d/c order dated 06/04/25, which █ did (attachment #35).
- 2) DHW completed audit of both medication carts on 5/26/25 for any missing medications. (attachment #26).
- 3) Meeting held on 5/28 by DHW with MedTech's and LPNs to discuss proper procedures when a med is not available. (attachments #27 and #28) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. █ 6/17/25).
- 4) Weekly cart /refrigerator audits by DHW to begin June 11th to ensure all meds ordered are in-house and available.
(DIRECTED: Beginning on 6/20/25: The administrator/designee shall review the medications for at least 6 different residents monthly to ensure all prescribed medications are present in the home and to ensure compliance with 2600.187d. █ 6/17/25).
- 5) ED to perform random quarterly audits of both carts (approximately 5 residents total) beginning July 1st to ensure we remain in compliance with 2600.187.d.
- 6) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented (█ - 07/09/2025)

224a - Preadmission Screen Form

20. Requirements

2600.

224a - Preadmission Screen Form (continued)

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

Description of Violation

No preadmission screening was completed for resident #2, who was admitted to the home on [REDACTED]

No preadmission screening was completed for resident #4, who was admitted to the home on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 06/17/2025)

- 1) Upon return to the building, DHW printed out paper copies of the Preadmissions screens for residents #2 and #4 and placed in their charts. (attachments 36 and 37).
- 2) DHW aware of regulations, so [REDACTED] audited all resident files the week of May 26-30 to ensure prescreens were printed and available to see in resident files.
- 3) DHW will monitor every new file effective immediately, as residents are admitted ensuring prescreen is completed, signed and placed in medical file, not to be removed for any reason.
- 4) ED to randomly audit all new files at the time of move-in beginning July 1st to ensure prescreen is present in plastic sleeve. This will keep us in compliance with 2600.224.a.
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/17/25.

DIRECTED: By 7/1/25: The administrator shall develop and implement a new admission checklist to ensure timely completion of resident preadmission screenings in accordance with 2600.224a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated by the administrator on the new checklist by 7/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/17/25).

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented ([REDACTED] - 07/09/2025)

225a - Assessment 15 Days

21. Requirements

2600.

225a - Assessment 15 Days (continued)

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 #2 was admitted to the home on [REDACTED] however, resident #2's assessment was not completed until [REDACTED]

Resident #4's medical evaluation, dated [REDACTED], includes diagnoses of Anxiety, CAD, B12 Deficiency, B/L Cataracts and Brain Lesion; however, these diagnoses are not indicated on resident #4's assessment, dated [REDACTED]

REPEAT VIOLATION: 1/3/2024

Plan of Correction

Directed ([REDACTED] - 06/17/2025)

- 1) Upon return to the building, DHW was able to print paper copies of both assessments dated [REDACTED] and place it in resident's files. (attachment #38).
- 2) Attachment #39 now has matching diagnoses.
- 3) Once community switches to complete electronic files in June 2025, all Med-Techs, LPNs and Administration staff will be given access to print records, which will allow surveyors to view records upon request. For long-term purposes, this new electronic system has a "tickler" to remind DHW when upcoming assessments are due. The warning will not disappear until new assessment is entered into the system. (DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/17/25).
- 4) During the week of May 26-30, all resident files were audited by DHW for properly completed and dated assessments.
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

DIRECTED: By 7/1/25: The administrator shall develop and implement a new admission checklist to ensure timely completion of resident assessments in accordance with 2600.225a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated by the administrator on the new checklist by 7/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/17/25).

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/09/2025)

225c - Additional Assessment

22. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on [REDACTED] however, resident #1's previous assessment was completed on [REDACTED]

Resident #3's most recent assessment is undated; however, was signed by the assessor as completed on [REDACTED] Also, resident #3's previous assessment was completed on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 06/17/2025)

- 1) Upon return to the building, DHW was able to print resident #1's assessment from [REDACTED] and resident #3's assessment from [REDACTED] and place them in their paper files. (attachments #40 and #41)
- 2) Once community switches to complete electronic files in June 2025, all Med-Techs, LPNs and Administration staff will be given access to print records, which will allow surveyors to view records upon request. For long-term purposes, this new electronic system has a "tickler" to remind DHW when upcoming assessments are due. The warning will not disappear until new assessment is entered into the system. (DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 6/17/25).
- 4) During the week of May 26-30, all resident files were audited by DHW for properly completed and dated assessments.
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

DIRECTED: By 6/30/25: The administrator shall develop and implement a tracking system to ensure timely completion of resident assessments in accordance with 2600.225c. Beginning on 7/1/25, the tracking system shall be reviewed/updated at least monthly by the administrator/designee. Documentation of the tracking system shall be kept. [REDACTED] 6/17/25).

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 07/01/2025

Implemented ([REDACTED] - 07/09/2025)

227a - Support Plan 30 Days

23. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

227a - Support Plan 30 Days (continued)

Description of Violation

Resident #2 was admitted to the home on [redacted] however, resident #2's support plan was not completed until [redacted]

Resident #4 was admitted to the home on [redacted]; however, resident #4's support plan was not completed until [redacted]

Plan of Correction

Directed ([redacted] - 06/17/2025)

- 1) Upon return to the building, DHW was able to print out paper copies of support plans dated [redacted] (attachment #38) and [redacted] (attachment #39) for these residents. [redacted] placed them in their paper files.
- 2) Once community switches to complete electronic files in June 2025, all Med-Techs, LPNs and Administration staff will be given access to print records, which will allow surveyors to view records upon request. For long-term purposes, this new electronic system has a "tickler" to remind DHW when upcoming assessments are due. The warning will not disappear until new assessment is entered into the system. (DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/17/25).
- 3) During the week of May 26-30, all resident files were audited by DHW for properly completed and dated assessments.
- 4) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

DIRECTED: By 7/1/25: The administrator shall develop and implement a new admission checklist to ensure timely completion of resident support plans in accordance with 2600.227a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated by the administrator on the new checklist by 7/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/17/25).

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented ([redacted] - 07/09/2025)

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 #2's support plan, dated [redacted] is not signed by the assessor.

227g -Support Plan Signatures (continued)

Plan of Correction

Directed (█ - 06/17/2025)

- 1) Upon return to the building, DHW was able to print out the paper copy of RASP that was signed on █ and uploaded to the system. (attachment #42)
- 2) Once community switches to complete electronic files in June 2025, all Med-Techs, LPNs and Administration staff will be given access to print records, which will allow surveyors to view records upon request. For long-term purposes, this new electronic system has a "tickler" to remind DHW when upcoming assessments are due. The warning will not disappear until new assessment is entered into the system. (DIRECTED: By 7/1/25: The administrator shall re-educate all management employees, including all designees, on the location of all resident records to ensure the home provides the Department immediate access to resident records upon request in accordance with 2600.5a. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 6/17/25).
- 3) During the week of May 26-30, all resident files were audited by DHW for properly completed and dated assessments.
- 4) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

DIRECTED: Beginning on 6/30/25: The administrator/designee shall audit at least 8 different resident support plans per month to ensure all individuals who participated in the development of the support plan have signed and dated the support plans. █ 6/17/25

DIRECTED: By 6/30/25: The administrator/designee shall re-educate all staff persons responsible for completing resident support plans on ensuring all individuals who participate in the development of the support plan sign and date the support plan. █ 6/17/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented (█ - 07/09/2025)

227i - Support Plan Accessible

25. Requirements

- 2600.
- 227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

Numerous staff persons indicated they do not have access to resident support plans.

REPEAT VIOLATION: 11/2/2023

227i - Support Plan Accessible (continued)

Plan of Correction

Directed () - 06/17/2025

- 1) Director of Health & Wellness (DHW) placed a copy of every resident's support plan in binder and placed binder in the wellness center on 5/24/25 where all staff have access. (attachment #43)
- 2) DHW responsible for updating binder as changes are made, resident's are admitted and discharged.
- 3) Executive Director will randomly audit Binder quarterly beginning July 1 to ensure we remain in compliance with 2600.227.i.
- 4) All staff present at meeting on 5/30 when the procedure and location of RASP binder was discussed by DHW. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. () 6/17/25)
- 5) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
 - reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

DIRECTED: Beginning on 6/30/25: The administrator shall inspect the home monthly to ensure all direct care staff persons have access to all resident support plans at all times. () 6/17/25

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: 06/30/2025

Implemented () - 07/09/2025

252 - Record Content

26. Requirements

2600.

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

- 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #1's photograph is undated, so it is unable to be determined if resident #1's photograph is less than 2 years old. Resident #1 was admitted to the home on ()

No photograph is present in resident #2's record, who was admitted to the home on ()

Resident #3's photograph is undated, so it is unable to be determined if resident #3's photograph is less than 2 years old. Resident #3 was admitted to the home on ()

Plan of Correction

Accept () - 06/17/2025

- 1) Following survey, all new photos taken of all residents and placed in their files with name and date. This was complete by 5/28/25. (attachments #44, #45 and #46)

252 - Record Content (continued)

- 2) Director of Health & Wellness responsible to update photos every year. [REDACTED] now has a tickler system set up that all photos will be taken the first week of January whether they need it or not.
- 3) Executive Director to randomly audit files beginning with next admission on 6/6/25 and every new file afterwards to ensure photo with date is present to remain in compliance with 2600.252.
- 4) Lastly, QMP meeting to be held with managers on Monday June 30 (attachment #49 - documentation to be kept by community and uploaded as proof of completion) to discuss in detail all items in 2600.26b to include:
- reportable incidents
 - complaint procedures
 - staff training
 - violations received and POC progress / adherence
 - resident / family councils

Proposed Overall Completion Date: 06/30/2025

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ([REDACTED] - 07/09/2025)