



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to AM RAFL, P.C.

LEGAL ENTITY

To operate NEW BRIGHTON PERSONAL CARE HOME

NAME OF FACILITY OR AGENCY

Located at 701 PENN AVENUE, NEW BRIGHTON, PA 15066

(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 68  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: \_\_\_\_\_

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 April 29, 2026 until July 29, 2026 ,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **456041**

*Janette Biderup*  
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: APRIL 29, 2026

[REDACTED]  
AM RAFI, P.C.  
[REDACTED]

RE: New Brighton Personal Care Home  
701 Penn Avenue  
New Brighton, PA 15066  
License/COC #: 456041

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 17, 2025, October 2, 2025, January 22, 2026, January 23, 2026 and February 4, 2026, 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 number 45604) dated March 5, 2026 to March 5, 2027, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from APRIL 29, 2026 to JULY 29, 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.

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

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

[REDACTED], Workload Manager  
Pennsylvania Department of Human Services  
Bureau of Human Services Licensing  
Room 631, Health and Welfare Building  
625 Forster Street  
Harrisburg, Pennsylvania 17120  
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]  
[REDACTED]  
[REDACTED]

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

**Facility Information**

**Name:** NEW BRIGHTON PERSONAL CARE HOME      **License #:** 45604      **License Expiration:** 03/05/2026  
**Address:** 701 PENN AVENUE, NEW BRIGHTON, PA 15066  
**County:** BEAVER      **Region:** WESTERN

**Administrator**

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

**Legal Entity**

**Name:** AM RAFI, P.C.

**Address:** [REDACTED]

**Phone:** [REDACTED]      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** Other      **Date:** 03/22/2024      **Issued By:** Borough of New Brighton

**Staffing Hours**

**Resident Support Staff:** 0      **Total Daily Staff:** 13      **Waking Staff:** 10

**Inspection Information**

**Type:** Full      **Notice:** Unannounced      **BHA Docket #:**  
**Reason:** Renewal, Monitoring      **Exit Conference Date:** 10/02/2025

**Inspection Dates and Department Representative**

09/17/2025    On Site: [REDACTED]

10/02/2025    On Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 68      **Residents Served:** 12

**Secured Dementia Care Unit**

**In Home:** No      **Area:**      **Capacity:**      **Residents Served:**

**Hospice**

**Current Residents:** 1

**Number of Residents Who:**

**Receive Supplemental Security Income:** 8      **Are 60 Years of Age or Older:** 11  
**Diagnosed with Mental Illness:** 8      **Diagnosed with Intellectual Disability:** 2  
**Have Mobility Need:** 1      **Have Physical Disability:** 0

## Inspections / Reviews

09/17/2025 Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: 11/14/2025

12/04/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/20/2025

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: 12/11/2025

03/27/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/16/2025

Reviewer: [REDACTED]

Follow-Up Type: *Bypass Document  
Submission*

04/21/2026 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/27/2026

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 [REDACTED], at approximately 10:35 a.m., a copy of 55 Pa. Code 2600 was not posted in a conspicuous and public place in the home.

On [REDACTED] at approximately 10:35 a.m., a copy of the most recent licensing inspection summary, dated [REDACTED], issued by the Department was not posted in a conspicuous and public place in the home.

## Plan of Correction

Accept [REDACTED] - 12/04/2025)

*Immediate Action: Upon identification of the violations on [REDACTED] at approximately 10:35 a.m., the facility administrator, [REDACTED] immediately obtained a current copy of 55 Pa. Code 2600 and the most recent licensing inspection summary, dated 1/3/25, issued by the Department. Both documents were posted in a clearly visible and accessible area within the home, specifically near the main entrance where residents, staff, and visitors can readily view them.*

*Corrective Action: The facility administrator, [REDACTED] reviewed all regulatory requirements outlined in 55 Pa. Code 2600, Section 3.c, with key staff members to ensure a clear understanding of the need to display the current license, the license inspection summary, and the chapter itself in a conspicuous and public place. A checklist of required postings was developed and implemented, and a compliance audit was conducted throughout the home to verify that all required documents are properly displayed. Any additional missing postings identified during the audit were promptly addressed and corrected.*

*Preventative Action: To prevent recurrence of this violation, the home has established a monthly compliance review schedule. The administrator, [REDACTED] will conduct routine inspections to confirm that all required documents—including the current license, the most recent licensing inspection summary, and 55 Pa. Code 2600—are continuously posted as mandated. Staff will receive ongoing training regarding posting requirements during quarterly meetings, and the compliance posting checklist will be integrated into the facility's standard operating procedures. Any changes in regulatory requirements or licensing status will be immediately reflected in the postings to ensure continuous compliance.*

Licensee's Proposed Overall Completion Date: 12/20/2025

Not Implemented [REDACTED] - 03/27/2026)

## 18 - Compliance With Laws

## 2. Requirements

2600.

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

## Description of Violation

*The Influenza Awareness Act, enacted [REDACTED] requires influenza information to be posted in a public place in the facility year-round. There was no information posted in the home in accordance with The Influenza Awareness Act.*

## 18 - Compliance With Laws (continued)

## Plan of Correction

Accept ( ) - 12/23/2025)

*Immediate Action: Upon discovering the violation on September 17, 2025, Administrator [REDACTED] immediately posted influenza information from the Department of Health in a highly visible location near the facility entrance, ensuring that all residents, staff, and visitors could easily access the required information. This action was completed by the administrator [REDACTED]*

*Corrective Action: To address the root cause of the violation, Administrator [REDACTED] reviewed the requirements of The Influenza Awareness Act and 55 Pa. Code 2600.18 with all facility staff. [REDACTED] incorporated influenza posting requirements into the facility's compliance checklist and conducted a comprehensive audit of the home to verify that all required postings were displayed. Any identified gaps were immediately corrected. These corrective actions will be completed by January 11, 2026*

*Preventive Action: To prevent future occurrences, Administrator [REDACTED] integrated influenza posting verification into the facility's monthly compliance reviews. [REDACTED] also implemented regular staff training on posting requirements and updated the compliance checklist to ensure ongoing adherence to all applicable health and safety regulations. All preventive actions will be completed by January 11, 2026, as well as monitoring every 30 days for the next 90 days .*

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented [REDACTED] - 03/27/2026)

## 25a - Written Contract and Review

## 3. 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 [REDACTED], resident-home contract, dated [REDACTED], was not dated when signed by the resident.

Resident [REDACTED] resident-home contract, dated [REDACTED] was not dated when signed by the resident.

Resident [REDACTED] admitted [REDACTED], did not have a resident-home contract completed until [REDACTED] and the contract was not dated when signed by the resident.

Resident [REDACTED] admitted, [REDACTED] did not have a resident-home contract completed until [REDACTED].

## Plan of Correction

Accept [REDACTED] 12/23/2025)

*Immediate Action: Upon identification of the contract violations, Administrator [REDACTED] immediately obtained the affected resident-home contracts and ensured that each contract was properly dated and signed by the residents. For Residents [REDACTED] and [REDACTED] who did not have timely contracts, Administrator [REDACTED] completed and reviewed the contracts with the residents and their designated persons, when applicable, and ensured that the documents were promptly dated and filed in their records. All immediate actions taken by Administrator [REDACTED] will be fully completed implementing this corrective action by January 11, 2026.*

**25a - Written Contract and Review (continued)**

*Corrective Action: To correct the underlying issue, Administrator [REDACTED] reviewed the requirements of 55 Pa. Code 2600.25(a) with all staff responsible for admissions and contract management. [REDACTED] established a standard operating procedure mandating that every resident-home contract must be completed, reviewed, explained, signed, and dated by both the resident (and designee, if applicable) and Administrator [REDACTED] or [REDACTED] designee before or within 24 hours of admission. Additionally, [REDACTED] implemented a compliance checklist and conducted a full audit of all existing contracts to confirm that each was properly completed and dated. All corrective actions performed by Administrator [REDACTED] will be completed by January 11, 2026.*

*Preventive Action: To prevent recurrence, Administrator [REDACTED] will provide ongoing staff training on admissions procedures and contract requirements during quarterly meetings. [REDACTED] will ensure that monthly audits of resident-home contracts are conducted to verify continued compliance, and [REDACTED] has updated the admissions checklist to include verification that all contracts are dated at the time of signing. Administrator [REDACTED] will also ensure that any regulatory changes are immediately communicated to staff and incorporated into the admissions process. All preventive measures will be completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented [REDACTED] - 03/27/2026)**

**25c1 - Personal Needs Allowance****4. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

1. Each resident shall retain, at a minimum, the current personal needs allowance as the resident's own funds for personal expenditure. A contract to the contrary is not valid. A personal needs allowance is the amount that a resident shall be permitted to keep for [REDACTED] personal use.

**Description of Violation**

*The resident-home contract for resident [REDACTED] dated [REDACTED] who receives [REDACTED], did not specify the amount of personal needs allowance the resident is to retain.*

*The resident-home contract for resident [REDACTED] dated [REDACTED], who receives [REDACTED], did not specify the amount of personal needs allowance the resident is to retain.*

**Plan of Correction**

**Accept [REDACTED] - 12/23/2025)**

*Immediate Action: Upon identifying the omission on [REDACTED], Administrator [REDACTED] immediately reviewed the resident-home contracts for Residents [REDACTED] and [REDACTED] amended the contracts the same day to clearly specify the current personal needs allowance each resident is entitled to retain, ensuring compliance with 55 Pa. Code 2600.25(c). Administrator [REDACTED] then ensured the updated contracts were promptly signed by the residents and himself, with copies provided to each resident and placed in their records. All immediate actions taken were completed by Administrator [REDACTED]*

*Corrective Action: Administrator [REDACTED] conducted a comprehensive review of all resident-home contracts for SSI recipients to verify that the personal needs allowance is explicitly stated as required. [REDACTED] provided targeted*

**25c1 - Personal Needs Allowance (continued)**

training to all staff responsible for admissions and contract management on the requirements of 55 Pa. Code 2600.25(c), emphasizing the necessity of including the personal needs allowance amount in every contract. Administrator [REDACTED] also updated the contract compliance checklist to require verification of this provision before any contract is finalized. All corrective measures will be completed by January 11, 2026.

Preventive Action: To prevent future violations, Administrator [REDACTED] will oversee monthly audits of all resident-home contracts to ensure that the personal needs allowance is consistently specified for SSI recipients. [REDACTED] will provide ongoing staff training on contract requirements during quarterly meetings and ensure that any regulatory changes are immediately communicated and incorporated into contract templates and procedures. Administrator [REDACTED] has also updated the admissions process to include a mandatory check for the personal needs allowance provision prior to contract completion. All preventive actions will be completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented [REDACTED] - 03/27/2026)

**25c3 - Annual Assessment****5. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

3. An explanation of the annual assessment, medical evaluation and support plan requirements and procedures, which shall be followed if either the assessment or the medical evaluation indicates the need of another and more appropriate level of care.

**Description of Violation**

The resident-home contract, for the following residents, on the following dates did not explain the annual assessment, medical evaluation and support plan requirements and procedures to be followed if the assessment or medical evaluation indicates the need for another or more appropriate level of care:

Resident [REDACTED] dated [REDACTED]  
 Resident [REDACTED] dated [REDACTED]  
 Resident [REDACTED] dated [REDACTED]

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

Immediate Action: Upon identifying the omission, Administrator [REDACTED] immediately reviewed the resident-home contracts for Residents [REDACTED] and [REDACTED] amended the contracts the same day to clearly specify the current personal needs allowance each resident is entitled to retain, ensuring compliance with 55 Pa. Code 2600.25(c). The updated contracts were promptly signed by the residents and Administrator [REDACTED] and copies were provided to each resident and placed in their records. All immediate actions overseen by Administrator [REDACTED] will be completed by January 11, 2026.

Corrective Action: Administrator [REDACTED] conducted a comprehensive review of all resident-home contracts for SSI recipients to verify that the personal needs allowance is explicitly stated. [REDACTED] provided targeted training to staff responsible for admissions and contract management on the requirements of 55 Pa. Code 2600.25(c), emphasizing

**25c3 - Annual Assessment (continued)**

the necessity of including the personal needs allowance amount in every contract. Additionally, Administrator [REDACTED] updated the contract compliance checklist to require verification of this provision before contracts are finalized. All corrective actions will be completed by January 11, 2026.

Preventive Action: To prevent future violations, Administrator [REDACTED] will ensure that monthly audits of resident-home contracts are conducted to confirm that the personal needs allowance is consistently specified for all SSI recipients. [REDACTED] will provide ongoing staff training on contract requirements during quarterly meetings and ensure that any regulatory changes are promptly communicated and incorporated into contract templates and procedures. Administrator [REDACTED] has also updated the admissions process to include a mandatory check for the personal needs allowance provision prior to contract completion. All preventive actions will be completed January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented [REDACTED] - 03/27/2026)

**25c4 - Payment Responsibility****6. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

4. The party responsible for payment.

**Description of Violation**

The resident-home contract, for the following residents, on the following dates did not specify the party responsible for payment:

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

**Plan of Correction**

Accept [REDACTED] 12/23/2025)

Immediate Action: Upon identifying the violations on September 26, 2025 (Residents [REDACTED] and [REDACTED] and May 2, 2025 (Resident [REDACTED] Administrator [REDACTED] promptly reviewed the resident-home contracts for Residents [REDACTED] and [REDACTED] immediately amended each contract to clearly include, as required by 55 Pa. Code 2600.25(c)(3), a specific explanation of the annual assessment, medical evaluation, and support plan requirements. [REDACTED] also ensured that the contracts outlined the procedures to be followed if an assessment or medical evaluation indicates the need for another or more appropriate level of care. The amended contracts were reviewed and signed by the residents and Administrator [REDACTED] with copies provided to all relevant parties. All immediate actions will be fully completed by January 11, 2026.

Corrective Action: Following the violations identified on September 26, 2025 (Residents [REDACTED] and [REDACTED] and May 2, 2025 (Resident [REDACTED] Administrator [REDACTED] provided targeted training to all staff responsible for admissions and contract management. This training emphasized the requirement that every resident-home contract must explicitly state the annual assessment, medical evaluation, and support plan requirements, along with procedures for

**25c4 - Payment Responsibility (continued)**

determining the need for another or more appropriate level of care, as mandated by 55 Pa. Code 2600.25(c)(3). Administrator [REDACTED] conducted a comprehensive audit of all resident-home contracts to confirm inclusion of the required language and updated both the admissions checklist and the facility's standard operating procedure to require verification of these provisions before contract finalization. All corrective actions will be completed by January 11, 2026.

Preventive Action: In response to the violations discovered on September 26, 2025 (Residents [REDACTED] and [REDACTED] and May 2, 2025 (Resident [REDACTED] Administrator [REDACTED] implemented preventive measures to ensure ongoing compliance. Monthly audits of all resident-home contracts will confirm continued inclusion of the required annual assessment, medical evaluation, and support plan information, as well as procedures for determining whether another or more appropriate level of care is needed. Staff will receive ongoing training during quarterly meetings, and any regulatory updates will be promptly incorporated into contract templates and admissions procedures. All preventive actions will be completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ([REDACTED] - 03/27/2026)

**25c5 - Telephone Calls****7. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

5. The method for payment of charges for long distance telephone calls.

**Description of Violation**

The resident-home contract, for the following residents, on the following dates did not specify the method of payment of charges for long distance phone calls:

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

**Plan of Correction**

Accept ([REDACTED] - 12/23/2025)

Immediate Action: Upon identifying the omission, Administrator [REDACTED] promptly reviewed the resident-home contracts for Residents [REDACTED] (dated 6/26/25), [REDACTED] (dated 9/26/25), and [REDACTED] (dated 5/2/25). Each contract was immediately amended by [REDACTED] to clearly specify the method of payment for charges related to long distance telephone calls in accordance with 55 Pa. Code 2600.25.c(5). The updated contracts were reviewed and signed by the residents and Administrator [REDACTED] and copies were provided to each resident and placed in their records. All immediate actions overseen by [REDACTED] will be completed by January 11, 2026.

Corrective Action: Administrator [REDACTED] conducted a comprehensive audit of all resident-home contracts to ensure the method of payment for long distance phone calls is explicitly stated. [REDACTED] provided targeted training to staff responsible for admissions and contract management on the requirements of 55 Pa. Code 2600.25.c(5), emphasizing the necessity of including this provision in every contract. [REDACTED] also updated the contract compliance checklist to require verification of this item prior to contract finalization. All corrective actions will be completed by January 11, 2026.

## 25c5 - Telephone Calls (continued)

*Preventive Action: To prevent future violations, Administrator [REDACTED] will conduct monthly audits of resident-home contracts to ensure the method of payment for long distance calls is consistently specified. [REDACTED] will provide ongoing staff training on contract requirements during quarterly meetings, promptly communicate any regulatory changes, and integrate them into contract templates and admissions procedures. The admissions process now includes a mandatory check for this provision before contract completion. All preventive actions will be completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Not Implemented** [REDACTED] - 03/27/2026)

## 25c6 - Refunds

## 8. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

6. The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

**Description of Violation**

*The resident-home contract, for the following residents, on the following dates did not specify the conditions under which refunds will be made, including the refund of admissions fees and refunds upon the resident's death:*

*Resident [REDACTED] dated [REDACTED]*

*Resident [REDACTED] dated [REDACTED]*

*Resident [REDACTED] dated [REDACTED]*

**Plan of Correction**

**Accept** [REDACTED] 12/23/2025)

*Immediate Action: Upon identifying the omission, Administrator [REDACTED] immediately reviewed the resident-home contracts for Resident [REDACTED] (dated 6/26/25), Resident [REDACTED] (dated 9/26/25), and Resident [REDACTED] (dated 5/2/25). Each contract was promptly amended by [REDACTED] to specify the conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death, as required by 55 Pa. Code 2600.25.c(6). The updated contracts were signed by the residents and [REDACTED] with copies provided to each resident and placed in their records. All immediate actions will be completed by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] conducted a comprehensive audit of all resident-home contracts to ensure that the conditions for refunds, including admissions fees and refunds upon a resident's death, are explicitly stated. [REDACTED] provided targeted training to staff responsible for admissions and contract management on the requirements of 55 Pa. Code 2600.25.c(6), emphasizing the necessity of including this provision in every contract. The contract compliance checklist was updated by [REDACTED] to require verification of the refund conditions prior to finalizing any contract. All corrective actions will be completed by January 11, 2026.*

*Preventive Action: To prevent future violations, Administrator [REDACTED] will conduct monthly audits of resident-home contracts to confirm that the conditions under which refunds are made are consistently specified, including those for admission fees and refunds upon a resident's death. [REDACTED] will provide ongoing staff*

**25c6 - Refunds (continued)**

training on contract requirements during quarterly meetings, promptly communicate regulatory changes, and integrate them into contract templates and admissions procedures. The admissions process now includes a mandatory check for this provision before contract completion. All preventive actions will be completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

**25c7 - Financial Assistance****9. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

7. The financial arrangements if assistance with financial management is to be provided.

**Description of Violation**

The resident-home contract, dated ( ) for resident ( ) who receives assistance with financial management, did not specify the arrangements under which this assistance will be provided.

**Plan of Correction**

Accept ( ) - 12/23/2025)

Immediate Action: Upon identifying the omission, Administrator ( ) promptly reviewed the resident-home contract for Resident ( ) (dated 5/2/25). The contract was immediately amended by ( ) to specify the financial arrangements under which assistance with financial management will be provided, in accordance with 55 Pa. Code 2600.25.c(7). The resident and ( ) reviewed and signed the updated contract, and copies were provided to the resident and placed in their records. All immediate actions will be completed by January 11, 2026.

Corrective Action: Administrator ( ) conducted a comprehensive audit of all resident-home contracts to ensure that any resident receiving assistance with financial management has explicit arrangements documented in their contracts. ( ) provided targeted training to staff responsible for admissions and contract management on the requirements of 55 Pa. Code 2600.25.c(7), emphasizing the inclusion of this provision in every relevant contract. The contract compliance checklist was updated by ( ) to require verification of these financial arrangements prior to contract finalization. All corrective actions will be completed by January 11, 2026.

Preventive Action: To prevent future violations, Administrator ( ) will conduct monthly audits of resident-home contracts to confirm that financial arrangement provisions for residents receiving assistance with financial management are consistently specified. ( ) will continue ongoing staff training on contract requirements during quarterly meetings and promptly communicate regulatory changes for incorporation into contract templates and admissions procedures. The admissions process now includes a mandatory check for this provision before contract completion. All preventive actions will be completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) 03/27/2026)

**25c8 - Smoking**

**10. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

8. The home's rules related to home services, including whether the home permits smoking.

**Description of Violation**

*The resident-home contracts for all residents did not include home rules related to home services, including whether the home permits smoking, as home rules were not established for the home.*

**Plan of Correction****Accepted** [REDACTED] 12/23/2025)

*Immediate Action: Upon identifying the violation, Administrator [REDACTED] promptly reviewed all resident-home contracts and amended them to include clearly stated home rules related to home services, specifically addressing whether smoking is permitted on the premises in accordance with 55 Pa. Code 2600.25.c(8). The updated contracts were reviewed and signed by each resident and [REDACTED] with copies provided to the residents and placed in their records. All immediate actions will be completed by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] conducted a comprehensive audit of all resident-home contracts to ensure that home rules, including policies on smoking and other home services, are explicitly documented. [REDACTED] provided targeted training to staff responsible for admissions and contract management on the requirements of 55 Pa. Code 2600.25.c(8), emphasizing the necessity of including these rules in every contract. The contract compliance checklist was updated by [REDACTED] to require verification of home rules prior to contract finalization. All corrective actions will be completed by January 11, 2026.*

*Preventive Action: To prevent future violations, Administrator [REDACTED] will conduct monthly audits of resident-home contracts to confirm that home rules, including smoking policies and other service-related provisions, are consistently specified. [REDACTED] will continue ongoing staff training on contract requirements during quarterly meetings and promptly communicate regulatory changes for integration into contract templates and admissions procedures. The admissions process now includes a mandatory check for this provision before contract completion. All preventive actions will be completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented** [REDACTED] - 03/27/2026)**25c9 - Termination****11. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

9. The conditions under which the agreement may be terminated including home closure as specified in § 2600.228 (relating to notification of termination).

**Description of Violation**

*The resident-home contract, dated [REDACTED] for resident [REDACTED] did not include conditions under which the agreement may be terminated including home closure.*

**Plan of Correction****Accepted** [REDACTED] - 12/23/2025)

*Immediate Action: Upon identifying the omission, Administrator [REDACTED] immediately reviewed the resident-home contract for Resident [REDACTED] (dated 5/2/25). The contract was promptly amended by [REDACTED] to specify*

**25c9 - Termination (continued)**

the conditions under which the agreement may be terminated, including home closure, in accordance with 55 Pa. Code 2600.25.c(9) and § 2600.228. The resident and [REDACTED] reviewed and signed the updated contract, and copies were provided to the resident and placed in their records. All immediate actions will be completed by January 11, 2026.

**Corrective Action:** Administrator [REDACTED] conducted a comprehensive audit of all resident-home contracts to ensure that the conditions for termination—including home closure—are explicitly stated as required by 55 Pa. Code 2600.25.c(9). Staff responsible for admissions and contract management received targeted training from [REDACTED] on these requirements, and the contract compliance checklist was updated to require verification of termination conditions prior to finalizing any contract. All corrective actions will be completed by January 11, 2026.

**Preventive Action:** To prevent future violations, Administrator [REDACTED] will conduct monthly audits of resident-home contracts to confirm that the conditions under which agreements may be terminated, including home closure, are consistently specified. [REDACTED] will continue ongoing staff training on contract requirements during quarterly meetings and promptly communicate regulatory changes for integration into contract templates and admissions procedures. The admissions process now includes a mandatory check for this provision before contract completion. All preventive actions will be completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Not Implemented** [REDACTED] - 03/27/2026)

**25c10 - Advance Notice****12. Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

10. A statement that the resident is entitled to at least 30 days' advance notice, in writing, of the home's request to change the contract.

**Description of Violation**

The resident-home contract, dated [REDACTED], for resident [REDACTED] did not include a statement that the resident is entitled to at least 30 days advanced written notice of the home's request for a change in the contract.

**Plan of Correction**

**Accept** [REDACTED] - 12/23/2025)

**Immediate Action:** Upon discovery of the omission, Administrator [REDACTED] promptly reviewed the resident-home contract for Resident [REDACTED] (dated 5/2/25) and amended it to clearly include a statement that the resident is entitled to at least 30 days' advance written notice of any proposed changes to the contract, as required by 55 Pa. Code 2600.25.c(10). The revised contract was reviewed and signed by both the resident and [REDACTED] with updated copies provided to the resident and filed in their records. All immediate actions will be completed by January 11, 2026.

**Corrective Action:** Administrator [REDACTED] conducted a comprehensive audit of all resident-home contracts to ensure each one contains the required 30-day advance written notice provision. Staff involved in admissions and contract management received targeted training from [REDACTED] on the requirements of 55 Pa. Code 2600.25.c(10), emphasizing the importance of including this statement in every contract. The contract compliance checklist was updated by [REDACTED] to require verification of this provision before finalizing any contract. All corrective actions will be completed by January 11, 2026.

## 25c10 Advance Notice (continued)

*Preventive Action: To prevent future violations, Administrator [REDACTED] will perform monthly audits of resident home contracts to confirm that the advance notice provision is consistently included. Ongoing staff training on contract requirements will continue during quarterly meetings, and regulatory changes will be communicated and integrated into contract templates and procedures by [REDACTED]. The admissions process includes a mandatory check for this provision prior to contract completion. All preventive actions will be completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Not Implemented** [REDACTED] - 03/27/2026)

## 25c12 - Bed Hold

## 13. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

**Description of Violation**

*The resident home contract, for the following residents, on the following dates, did not include the charges for holding a bed during an absence:*

*Resident [REDACTED] dated [REDACTED]*

*Resident [REDACTED] dated [REDACTED]*

**Plan of Correction**

**Accept** [REDACTED] 12/23/2025)

*Immediate Action: Upon discovery, Administrator [REDACTED] immediately reviewed the resident home contracts for Residents [REDACTED] (6/26/25) and [REDACTED] (5/2/25). The contracts were promptly amended by [REDACTED] to specify the charges for holding a bed during hospitalization or other extended absence, in accordance with 55 Pa. Code 2600.25.c(12). Both residents and [REDACTED] reviewed and signed the updated contracts, with revised copies provided to each resident and filed in their records. All immediate actions will be completed by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] conducted a comprehensive audit of all resident home contracts to ensure that the required provision regarding charges for holding a bed is explicitly documented. Staff involved in admissions and contract management received targeted training from [REDACTED] on the requirements of 55 Pa. Code 2600.25.c(12), emphasizing the necessity of including this information in every contract. The contract compliance checklist was updated by [REDACTED] to require verification of bed hold charge provisions prior to finalizing any contract. All corrective actions will be completed by January 11, 2026.*

*Preventive Action: To prevent future violations, Administrator [REDACTED] will conduct monthly audits of resident home contracts to confirm that bed hold charges during absences are consistently specified. Ongoing staff training on contract requirements will continue during quarterly meetings, and any regulatory changes will be promptly communicated and incorporated into contract templates and admissions procedures by [REDACTED]. The admissions process now includes a mandatory check for this provision before contract completion. All preventive actions will be completed by January 11, 2026.*

## 25c12 - Bed Hold (continued)

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

## 25c13 - Complaint Procedure

## 14. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

13. Written information on the resident's rights and complaint procedures as specified in § 2600.41 (relating to notification of rights and complaint procedures).

## Description of Violation

The resident-home contract, for the following residents, on the following dates did not include written information on the residents' rights and the complaint procedures:

Resident ( ) dated ( )

Resident ( ) dated ( )

Resident ( ) dated ( )

## Plan of Correction

Accept ( ) 12/23/2025)

Immediate Action: Upon identifying that the resident-home contracts for Residents ( ) (6/26/25), ( ) (6/26/25), and ( ) (5/2/25) did not include the required written information on residents' rights and complaint procedures as mandated by 2600.25(c)(13), the administrator, ( ) immediately met with each resident (or their responsible party) to provide the missing written materials. Updated contract addendums reflecting the residents' rights and complaint procedures were reviewed, signed, and placed in each resident's file. Staff were also notified of the deficiency and instructed to ensure that no further contracts are issued without these components. The person responsible for this action is Administrator ( ) and the completion date is January 11, 2026.

Corrective Action: Administrator ( ) audited all current resident contracts to confirm that each contains the required written information on resident rights and complaint procedures. Any contract found to be incomplete was corrected through issuance of an addendum and documented accordingly. The facility's contract template was revised by ( ) to permanently embed the required 2600.41 information in a clearly marked section, ensuring that all future contracts automatically meet regulatory requirements. The person responsible for this action is Administrator ( ) and the completion date is January 11, 2026.

Preventative Action: Administrator ( ) implemented a standardized admissions checklist that includes verification of the resident-rights and complaint-procedures section before a contract can be finalized. Administrative staff involved in admissions were retrained on 2600.25(c) requirements, with annual refresher training scheduled by ( ). Monthly quality-assurance audits of new contracts will be conducted by ( ) to ensure sustained compliance and prevent recurrence of this violation. The completion date for these preventative actions is January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

## 25b SOPa - Rent Rebate: Contract

## 15. Requirements

2600.

25b.a. The resident-home contract is to include whether the home collects a portion of a resident's rent rebate under § 2600.25(d) (relating to resident-home contract).

## Description of Violation

*The resident-home contract, for the following residents, on the following dates, did not indicate whether the home collects a portion of the resident's rent rebate benefit:*

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

Resident [REDACTED] dated [REDACTED]

## Plan of Correction

Accept [REDACTED] - 12/23/2025)

*Immediate Action: Upon discovery that the resident-home contracts for Residents [REDACTED] (6/26/25), [REDACTED] (6/26/25), [REDACTED] (9/26/25), and [REDACTED] (9/26/25) did not indicate whether the home collects a portion of the resident's rent rebate benefit as required by §2600.25(b)(a), Administrator [REDACTED] immediately met with each resident or their representative to review and update their contracts. Addendums specifying the facility's policy on rent rebate collection were completed, signed, and filed in each resident's record. Staff responsible for admissions were informed by [REDACTED] of the missing information so no further incomplete contracts are issued. The person responsible is [REDACTED] with completion by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] conducted a comprehensive review of all active resident-home contracts to ensure the rent rebate section is clearly documented. Any contract missing this required information was updated through formal addendums and re-signed by the resident or representative. [REDACTED] revised the facility's standard contract template to include a dedicated, mandatory section confirming whether the home collects any portion of a resident's rent rebate, in accordance with §2600.25(d). The responsible person is [REDACTED] with completion by January 11, 2026.*

*Preventative Action: Administrator [REDACTED] developed a mandatory admissions checklist to confirm the rent rebate disclosure is completed prior to finalizing any new contract. All administrative and admissions staff were retrained on §2600.25 requirements, including proper documentation practices, by [REDACTED]. To ensure ongoing compliance, [REDACTED] will conduct monthly audits of newly executed contracts, and deficiencies will be addressed immediately to prevent recurrence of this violation. Completion date is January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ([REDACTED] - 03/27/2026)

## 26b - Quality Management Plan Content

## 16. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.

26b - Quality Management Plan Content (*continued*)

- 3. Staff person training.
- 5. Resident or family councils, or both, if applicable.

**Description of Violation**

*The home's quality management plan did not include a plan to address the periodic review and evaluation of the following:*

*Reportable incidents and condition reporting procedures*

*Staff person training*

*Licensing violations and plans of correction*

*Resident or family councils*

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

*Immediate Action: Upon identification of the deficiency, Administrator [REDACTED] immediately updated the quality management (QM) plan to include the required components: periodic review of reportable incidents and condition reporting procedures, staff person training, licensing violations and plans of correction, and resident or family councils. The revised QM plan was reviewed with administrative staff and implemented immediately by [REDACTED]. Documentation was completed to verify these additions were incorporated without delay. The responsible person is [REDACTED] with completion by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] conducted a full review of the existing QM system to ensure all required elements under §2600.26(b) were properly addressed and integrated. The QM plan was rewritten by [REDACTED] to outline methods, timelines, and responsible personnel for reviewing reportable incidents, complaint procedures, staff training, licensing violations, and resident/family council activities. [REDACTED] met with relevant department leads to ensure understanding of their responsibilities and to align reporting practices with the updated QM plan. Completion date is January 11, 2026.*

*Preventative Action: Administrator [REDACTED] established a quarterly QM review schedule to ensure all required components are consistently evaluated and documented. Administrative and department staff were retrained on §2600.26 QM requirements, with annual refresher training scheduled by [REDACTED]. [REDACTED] will conduct semiannual audits of the QM plan to verify that all required elements remain current, effective, and fully compliant to prevent recurrence of this violation. Completion date is January 11, 2026.*

**Licensee's Proposed Overall Completion Date:** 01/11/2026

Not Implemented [REDACTED] 03/27/2026)

## 41a - Complaint w/o Retaliation

**17. Requirements**

2600.

- 41.a. Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter. Retaliation includes discharge or transfer from the home.

**41a Complaint w/o Retaliation (continued)****Description of Violation**

Resident [REDACTED] admitted [REDACTED] was not educated on [REDACTED] resident rights or [REDACTED] right to lodge complaints without intimidation, retaliation, or threats of retaliation.

**Plan of Correction****Accept [REDACTED] - 12/23/2025)**

*Immediate Action:* When it was identified that Resident [REDACTED] admitted on 5/2/25, had not been educated on resident rights or the right to lodge complaints without intimidation or retaliation as required by §2600.41(a), the administrator, [REDACTED] immediately met with the resident (and designated person, if applicable) to provide a full explanation of these rights. The required written materials were reviewed in detail, and the resident acknowledged receipt through signed documentation, which was placed in the resident's file. Staff involved in the admission were notified of the oversight and instructed to ensure this education is completed for all future admissions. The person responsible is Administrator [REDACTED] and the completion date is January 11, 2026.

*Corrective Action:* Administrator [REDACTED] conducted a review of all current resident files to verify that each resident had received proper resident rights education and documentation. Any missing or incomplete education was corrected immediately. The admission packet was updated to clearly include required rights information, and a mandatory signature form was added to confirm that education was provided at admission. Staff responsible for admissions were retrained on the requirements of §2600.41(a) to ensure consistent understanding and compliance. Administrator [REDACTED] is responsible for completion by January 11, 2026.

*Preventative Action:* A standardized admission checklist was implemented requiring verification that resident rights education is completed and documented before the admission process can be finalized. Administrator [REDACTED] will conduct monthly audits of newly admitted residents' files to ensure ongoing compliance. Additionally, admission staff will participate in annual refresher training on resident rights and complaint protections to prevent recurrence of this violation. The responsible person is Administrator [REDACTED] with completion by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Implemented [REDACTED] 03/27/2026)****41c - Rights Poster****18. Requirements**

2600.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

**Description of Violation**

On [REDACTED], at approximately 10:35 a.m., the Department's resident rights poster was not posted in a conspicuous and public place in the home.

**Plan of Correction****Accept [REDACTED] - 12/23/2025)**

*Immediate Action:* Upon discovering on 9/17/25 at approximately 10:35 a.m. that the Department's resident rights

**41c - Rights Poster (continued)**

poster was not displayed in a conspicuous and public place as required by §2600.41(c), staff immediately located the poster and posted it in a highly visible area accessible to all residents, visitors, and staff. The administrator, [REDACTED] verified proper placement and documented the correction. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

**Corrective Action:** Administrator [REDACTED] conducted a walkthrough of the entire home to ensure all required postings—including the resident rights poster—were present, visible, and appropriately placed. Staff were reeducated on the requirement that the resident rights poster must remain continuously displayed in a public and easily accessible location. The facility's posting procedures were updated to include clear expectations for monitoring required postings. Completion is the responsibility of Administrator [REDACTED] by January 11, 2026.

**Preventative Action:** A weekly environmental checklist was implemented, requiring supervisors to confirm that the resident rights poster and all other mandated postings remain properly displayed. Administrator [REDACTED] will conduct monthly spot checks to ensure sustained compliance. Staff will also receive annual refresher training on regulatory posting requirements to prevent recurrence of this violation. The responsible person is Administrator [REDACTED] with completion by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented [REDACTED] - 03/27/2026)

**42e - Telephone Access****19. Requirements**

2600.

42.e. A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

**Description of Violation**

On [REDACTED], the resident telephone located in the main lobby of the home was not portable, was connected by a cord to the landline, and was located directly across from the staff office, which did not afford residents the ability to make telephone calls in private.

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

**Immediate Action:** Upon identifying on 9/17/25 that the resident telephone in the main lobby was not portable, was corded, and located in a position that did not allow residents to make private calls as required by §2600.42(e), the home immediately provided residents access to a portable cordless phone in a designated private area. Staff informed residents of the temporary private-call option while a permanent solution was implemented. Administrator [REDACTED] is responsible, with actions completed by January 11, 2026.

**Corrective Action:** The facility, under the direction of Administrator [REDACTED] installed a portable, cordless phone to ensure residents have access to a private space for phone calls away from staff offices and common traffic. Signage directing residents to the private phone area was posted. All staff were trained on the updated procedure to assist residents in accessing the private telephone option when needed. Completion is ensured by Administrator [REDACTED] with a target date of January 11, 2026.

**Preventative Action:** The home, led by Administrator [REDACTED] added telephone privacy checks to its

**42e Telephone Access (continued)**

monthly environmental audit to ensure continued compliance with §2600.42(e). Any changes to phone placement or equipment will require administrative approval to prevent recurrence. Staff will receive annual refresher training on residents' rights to telephone privacy, reinforcing expectations and maintaining long term compliance. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented [REDACTED] 03/27/2026)

**42s - Privacy****20. Requirements**

2600.

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

**Description of Violation**

On [REDACTED] at approximately 10:59 a.m., the men's common use bathroom, near the men's community room [REDACTED], had no means to be locked from the inside, as it was equipped with a key locking device that could be locked from the hallway only.

On [REDACTED] at approximately 11:15 a.m., the men's multi use common bathroom, next to bedroom [REDACTED] containing 2 toilets with individual doors that did not lock, and 3 open shower areas with curtains, was not equipped with any type of locking device on the door.

On [REDACTED], at approximately 2:55 p.m., the shared bathroom in bedroom [REDACTED], was not equipped with any type of locking device on the door.

On [REDACTED], at approximately 2:56 p.m., the women's common use bathroom, across from room [REDACTED] was not equipped with any type of locking device on the door.

On [REDACTED] at approximately 4:45 p.m., the shared resident bedroom door, leading from the women's television common space to bedroom [REDACTED] did not close.

**Plan of Correction**

Accepted [REDACTED] - 12/23/2025)

Immediate Action: When it was identified on 9/17/25 and 10/2/25 that multiple resident bathrooms and a shared bedroom lacked proper locking mechanisms or the ability for doors to close compromising resident privacy during bathing, dressing, and personal care the administrator immediately restricted use of the affected bathrooms and bedroom until temporary privacy measures (e.g., portable privacy signs, temporary locks, and supervision protocols) were put in place. Maintenance staff were dispatched by Administrator [REDACTED] the same day to evaluate each location and implement immediate fixes where possible. The responsible person is Administrator [REDACTED] with completion by January 11, 2026

Corrective Action: Administrator [REDACTED] ensured all identified bathroom doors were equipped with appropriate interior locking, privacy compliant devices that allow residents to secure the door from the inside while still permitting emergency access by staff. The shared resident bedroom door leading to bedroom 89 was repaired

**42s - Privacy (continued)**

so it closes fully and securely. A complete inspection of all resident bathrooms and bedrooms throughout the home was conducted to identify and correct any additional privacy concerns. Staff were retrained on resident privacy rights under §2600.42(s) and instructed to report any privacy-related maintenance issues immediately. Completion is the responsibility of Administrator [REDACTED] by January 11, 2026.

*Preventative Action:* A monthly environmental safety and privacy audit was implemented to verify that all resident-use bathrooms and bedrooms maintain functioning locks, properly closing doors, and appropriate privacy features. Maintenance response procedures were updated to prioritize privacy-related repairs. Annual staff training on resident privacy rights and physical-environment standards required under §2600.42(s) has been added to the training schedule to ensure ongoing compliance and prevent recurrence of these violations. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented [REDACTED] - 03/27/2026)

**51 - Criminal Background Check****21. Requirements**

2600.

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

**Description of Violation**

Staff person A, hired [REDACTED], did not have a criminal history check completed.

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

*Immediate Action:* Upon discovering that Staff Person A, hired on 7/16/25, did not have a criminal history check completed as required by §2600.51, the administrator, [REDACTED] immediately removed the staff person from all resident-contact duties. A criminal history check was initiated the same day, and Staff Person A was not permitted to return to work until the results were received, reviewed, and found to be compliant with the Older Adult Protective Services Act and 6 Pa. Code Chapter 15. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

*Corrective Action:* Administrator [REDACTED] conducted a review of all current employee files to verify that required criminal history checks were completed for all staff. Any missing or incomplete documentation was obtained immediately. The hiring process was revised to require verification of completed criminal history checks before any new employee is permitted to begin work. Administrative staff responsible for onboarding were retrained on §2600.51 requirements and proper documentation procedures. Completion is ensured by Administrator [REDACTED] by January 11, 2026.

*Preventative Action:* Administrator [REDACTED] implemented a pre-employment compliance checklist that includes criminal history checks as a mandatory step prior to orientation or scheduling. Monthly audits of personnel files will be conducted to ensure ongoing compliance with all background check requirements. Annual training for administrative and hiring staff was added to reinforce regulatory expectations and prevent recurrence of this violation. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

## 51 Criminal Background Check (continued)

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented ( ) - 03/27/2026)

## 60a - Staff/Support Plan

## 22. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

## Description of Violation

On [REDACTED], there were 12 residents in the home, including 1 resident with mobility needs requiring assistance of 2 staff persons to evacuate in an emergency. On this date, there was only 1 direct care staff person working in the home to assist residents to evacuate in the event of an emergency from 8:00 p.m. 12:00 a.m. as well as on [REDACTED] and 12:00 a.m. 7:00 a.m. and 8:00 p.m. 12:00 a.m. on [REDACTED]

## Plan of Correction

Accept [REDACTED] - 12/23/2025)

Immediate Action: Upon identifying that inadequate staffing occurred on 9/15/25 9/17/25 leaving only one direct care staff person on duty during shifts when a resident requiring two person assistance for emergency evacuation was present the administrator, [REDACTED] immediately adjusted staffing schedules to ensure a minimum of two direct care staff were on duty at all times. Additional staff were called in to cover upcoming shifts, and the resident requiring two person assistance was reassessed to ensure immediate safety needs were fully met. Administrator [REDACTED] is responsible, with completion by January 11, 2026

Corrective Action: Administrator [REDACTED] completed a comprehensive review of the staffing schedule, resident assessments, and support plans to ensure full compliance with §2600.60(a). Staffing patterns were restructured to align with the needs of residents, particularly those requiring two person assistance for emergency evacuation. The facility's staffing policy was updated to specify minimum staffing levels based on resident care needs and emergency evacuation requirements. All scheduling personnel were retrained on the applicable regulatory requirements and the importance of matching staffing to assessment driven needs. Completion is the responsibility of Administrator [REDACTED] with a target date of January 11, 2026.

Preventative Action: The administrator, [REDACTED] implemented a weekly staffing audit to ensure schedules consistently meet regulatory and resident specific requirements. A staffing contingency plan was created to guarantee adequate coverage during call offs, emergencies, or scheduling gaps. Annual training for administrative and scheduling staff was added to reinforce compliance with §2600.60(a). Resident assessments and support plans will be reviewed quarterly and after any significant change in condition to ensure staffing levels remain appropriate and prevent recurrence of this violation. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented [REDACTED] 03/27/2026)

## 63a - First Aid/CPR Training

## 23. 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

On multiple dates and times, 12 residents were present in the home; however, there were no staff present in the home that were certified in first aid and obstructed airway techniques or CPR to include:

On [REDACTED], from 7:00 p.m. to 11:00 p.m. and from 11:00 p.m. to 7:00 a.m.

On [REDACTED], from 8:00 p.m. to 11:00 p.m. and from 11:00 p.m. to 7:00 a.m.

On [REDACTED], from 7:00 a.m. to 3:00 p.m., from 3:00 p.m. to 11:00 p.m., and from 11:00 p.m. to 7:00 a.m.

On [REDACTED], from 7:00 p.m. to 11:00 p.m. and from 11:00 p.m. to 7:00 a.m.

On [REDACTED], from 8:00 p.m. to 11:00 p.m. and from 11:00 p.m. to 7:00 a.m.

On [REDACTED], from 7:00 a.m. to 3:00 p.m., from 3:00 p.m. to 11:00 p.m., and from 11:00 p.m. to 7:00 a.m.

## Plan of Correction

Accept [REDACTED] - 12/23/2025)

Immediate Action: Upon discovering that on multiple dates in September 2025 no staff certified in first aid, CPR, or obstructed airway techniques were present while 12 residents were in the home—contrary to §2600.63(a)—the administrator, [REDACTED] immediately adjusted staffing assignments to ensure that a certified staff person was on-site at all times. Staff currently lacking certification were temporarily restricted from sole coverage of shifts, and certified personnel were contacted to cover upcoming shifts until compliance was restored. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

Corrective Action: Administrator [REDACTED] conducted a thorough review of staff training records to identify employees missing current certifications in first aid, CPR, and obstructed airway techniques. Mandatory training sessions were promptly scheduled, and all uncertified staff were enrolled and required to complete certification. Staffing schedules were restructured to guarantee that at least one certified staff member is present on every shift without exception. Facility scheduling and training policies were updated to align with §2600.63(a). Completion is ensured by Administrator [REDACTED] by January 11, 2026.

Preventative Action: The facility's administrator, [REDACTED] implemented a certification tracking system to monitor expiration dates and ensure timely recertification for all relevant staff. Monthly audits of staffing schedules and training records will be conducted to verify that a certified staff person is always present in the home. Annual training for administrative and scheduling staff was added to reinforce compliance with §2600.63(a) and prevent recurrence of this violation. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented [REDACTED] 03/27/2026)

## 65a - FS Orientation 1st Day

## 24. Requirements

2600.

65a - FS Orientation 1st Day (*continued*)

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

**Description of Violation**

Staff person A, hired [REDACTED], and staff person E, hired [REDACTED] did not receive orientation training on the following topics:

*Evacuation procedures*

*Staff duties and responsibilities during fire drills*

**Plan of Correction**

**Accept** [REDACTED] - 12/23/2025)

*Immediate Action: Upon discovering that Staff Person A (hired 7/16/25) and Staff Person E (hired 7/13/25) had not received orientation training on evacuation procedures and staff responsibilities during fire drills, the administrator, [REDACTED] immediately provided both staff members with one-on-one training covering general fire safety, evacuation procedures, and their duties during fire drills and emergencies. Documentation of this training was completed and added to their personnel files to reflect compliance with §2600.65(a). Administrator [REDACTED] is responsible, with completion by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] reviewed all current staff orientation records to confirm that each employee received complete fire safety and emergency preparedness training. Any gaps identified were addressed through immediate training sessions. The facility's orientation checklist was revised to require signed confirmation of completion for fire safety and emergency preparedness topics—including evacuation procedures and staff responsibilities during drills—before staff can assume independent duties. Administrator [REDACTED] is responsible for completion by January 11, 2026.*

*Preventative Action: The home's administrator, [REDACTED] implemented a mandatory orientation audit for all new hires to verify completion of fire safety and emergency preparedness training prior to or during the first workday. Annual refresher training on fire drills and evacuation responsibilities was added for all staff. Additionally, the administrator will conduct quarterly audits of personnel files to ensure that all orientation requirements are consistently documented and compliant with §2600.65(a), preventing recurrence of this violation. Administrator [REDACTED] is responsible, with completion by January 11, 2026*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented** [REDACTED] - 03/27/2026)

## 65b - Rights/Abuse 40 Hours

**25. 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:

2. Emergency medical plan.

**65b - Rights/Abuse 40 Hours (continued)**

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

Staff person A, hired [REDACTED] and staff person F, hired [REDACTED], did not complete orientation on the following topics:  
 Mandatory reporting of abuse and neglect under OAPSA  
 Reporting of reportable incidents and conditions.

Staff person E, hired [REDACTED], did not complete orientation the following topics:  
 Emergency medical plan  
 Mandatory reporting of abuse and neglect under OAPSA  
 Reporting of reportable incidents and conditions

**Plan of Correction****Accept [REDACTED] 12/23/2025)**

*Immediate Action:* Upon discovering that Staff Person A (hired 7/16/25), Staff Person F (hired 8/12/25), and Staff Person E (hired 7/13/25) had not completed orientation on mandatory reporting of abuse and neglect under OAPSA, reporting of reportable incidents and conditions, and/or the emergency medical plan as required by §2600.65(b), the administrator, [REDACTED] immediately provided targeted orientation training to each staff member. Training included the emergency medical plan, mandatory abuse reporting procedures, and proper documentation and reporting of incidents. Completion of the training was documented and placed in each personnel file. Administrator [REDACTED] is responsible, with completion by January 11, 2026.

*Corrective Action:* Administrator [REDACTED] performed a full review of all current staff orientation records to identify any staff with incomplete orientation training. Any deficiencies were corrected immediately through in-person or virtual sessions. The orientation process was updated to include a signed checklist confirming completion of all required topics within 40 scheduled working hours, ensuring compliance with §2600.65(b). Supervisors were retrained on tracking and verifying orientation completion for new hires. Completion is the responsibility of Administrator [REDACTED] with a target date of January 11, 2026.

*Preventative Action:* The home's administrator, [REDACTED] implemented a monitoring system to track completion of orientation topics within the 40-hour timeframe for all new staff. Quarterly audits of personnel files will be conducted to ensure orientation compliance is consistently documented. Annual refresher training for supervisors and administrative staff was added to reinforce compliance with §2600.65(b) and prevent recurrence of incomplete staff orientation. Administrator [REDACTED] is responsible, with completion by January 11, 2026

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented [REDACTED] - 03/27/2026)****66a - Staff Training Plan****26. Requirements**

2600.

66.a. A staff training plan shall be developed annually.

## 66a - Staff Training Plan (continued)

**Description of Violation**

The home did not have an annual staff training plan developed.

**Plan of Correction**

Accepted [REDACTED] - 12/23/2025)

*Immediate Action: Upon identifying that the home did not have an annual staff training plan in place as required by §2600.66(a), the administrator, [REDACTED] immediately notified all department leads and staff of the deficiency. Temporary training sessions were scheduled to address essential topics to ensure staff competency while a formal training plan was developed. Documentation of these interim trainings was recorded for compliance purposes. Administrator [REDACTED] is responsible, with completion by January 11, 2026.*

*Corrective Action: Administrator [REDACTED] developed and approved a comprehensive annual staff training plan that covers mandatory topics, training frequency, responsible trainers, and methods of delivery. Staff were scheduled to complete the sessions outlined in the plan, and completion records were documented in personnel files. The plan was reviewed with staff leadership to ensure it meets all regulatory requirements. Completion is ensured by Administrator [REDACTED] by January 11, 2026.*

*Preventative Action: A process was implemented to review and update the annual training plan each year prior to the start of the calendar year. Quarterly audits will verify that the training plan is current, implemented, and fully documented. Annual staff training requirements and compliance monitoring will be added to the administrative calendar to prevent future lapses in planning or execution. Administrator [REDACTED] is responsible, with completion by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented [REDACTED] - 03/27/2026)

## 82b - Poisonous Material Storage

**27. Requirements**

2600.

82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

**Description of Violation**

On [REDACTED], at approximately 12:05 p.m., a can of Raid was stored in the kitchen near the window.

**Plan of Correction**

Accepted [REDACTED] - 12/23/2025)

*Immediate Action: Upon discovering on 9/17/25 at approximately 12:05 p.m. that a can of Raid was stored in the kitchen near a window and in proximity to food preparation areas, staff immediately removed the chemical from the kitchen and placed it into a locked hazardous material storage area. The administrator, [REDACTED] who is responsible for ensuring correction, verified the area was safe for food preparation before kitchen activities resumed. This immediate action will be fully completed by January 11, 2026.*

*Corrective Action: A full inspection of all kitchen storage and food preparation areas was conducted to confirm that no other poisonous materials were improperly stored. Staff were retrained on hazardous material storage requirements in accordance with §2600.82(b), and policies and procedures were updated to identify proper storage locations. The responsible person, Administrator [REDACTED] will ensure these corrective measures are completed by January 11, 2026.*

**82b - Poisonous Material Storage (continued)**

*Preventative Action: Monthly environmental safety audits were implemented to ensure proper storage of hazardous materials, and annual refresher training was added to reinforce safe storage practices. Signage and labeled storage areas were installed to prevent recurrence. These preventative measures will be overseen by Administrator [REDACTED] and will be completed by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ([REDACTED] - 03/27/2026)

**82c - Locking Poisonous Materials****28. Requirements**

2600.

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

**Description of Violation**

On [REDACTED] at approximately 11:52 a.m., A bottle of heavy-duty floor stripper, a bottle of Shinline emulsifier plus, and finish & wax stripper bottles with labels indicating "immediately call poison control center or physician" under first aid, were unlocked, unattended, and accessible to residents in the chemical room, located in the basement of the home. Not all residents of the home, including resident [REDACTED] have been assessed capable of recognizing and using poisons safely.

**Plan of Correction**

Accept ([REDACTED] 12/23/2025)

*Immediate Action: Upon discovering on 9/17/25 at approximately 11:52 a.m. that several hazardous chemicals were unlocked and accessible to residents in the basement chemical room, staff immediately secured all chemicals in a locked cabinet and restricted access until the area was confirmed safe. The responsible person, Administrator [REDACTED] ensured staff were informed of the safety concern. This immediate action will be completed by January 11, 2026.*

*Corrective Action: A full chemical inventory was completed and all hazardous materials were relocated to locked storage areas inaccessible to residents. Policies were updated to ensure poisonous substances remain secured unless a resident assessment supports safe access. Staff were retrained on §2600.82(c) requirements. Administrator [REDACTED] is responsible for ensuring completion of these corrective actions by January 11, 2026.*

*Preventative Action: Monthly audits of all chemical storage areas were implemented to ensure chemicals remain secured. Staff will receive annual refresher training on proper storage and chemical safety, and resident assessments will be reviewed periodically. Administrator [REDACTED] the responsible party, will ensure preventative actions are completed by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ([REDACTED] 03/27/2026)

**85a - Sanitary Conditions****29. Requirements**

**85a Sanitary Conditions (continued)**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On [REDACTED], at approximately 10:45 a.m., there was a pile of lint strips, removed from the dryer, several plastic bags and used dryer sheets piled up next to the washer machine on the floor of the laundry area.

On [REDACTED], at approximately 10:55 a.m., a piece of fecal like matter, measuring approximately ¼ inch x ¼ inch, was on the floor of the shower, in the common use men's bathroom near the men's community room [REDACTED]. Additionally, there was a thin layer of fecal like matter smeared on the toilet seat and a foul urine odor that could be smelled in the hallway.

On [REDACTED] at approximately 10:55 a.m., 2 used washcloths were observed laying on the floor of the shower in the common use men's bathroom near the men's community room [REDACTED].

On [REDACTED] at approximately 2:56 p.m., a used washcloth was observed hanging on the shower assist bar in the women's common use shower, across from room [REDACTED].

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

*Immediate Action:* Upon identifying unsanitary conditions on 9/17/25, including lint piles, fecal matter, urine odors, and used washcloths, staff immediately cleaned and disinfected all affected areas. Maintenance and housekeeping staff were supervised to prevent resident exposure. These steps were overseen by Administrator [REDACTED] who will ensure all immediate actions are completed by January 11, 2026.

*Corrective Action:* A thorough sanitation inspection of the entire facility was conducted, and housekeeping procedures were revised to require more frequent cleaning rounds. Staff were retrained on cleaning protocols, infection control, and §2600.85(a). The responsible person, Administrator [REDACTED] will ensure full completion by January 11, 2026.

*Preventative Action:* A sanitation monitoring log was implemented for routine inspections of bathrooms, laundry rooms, and common areas. Weekly administrative walk-throughs were added, and annual sanitation and infection control training will be required. Administrator [REDACTED] is responsible for ensuring these preventative measures are completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented [REDACTED] - 03/27/2026)

**85d Trash Receptacles****31. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], at approximately 9:15 a.m., 2 large trash cans in the main kitchen, in the basement, were ½ full of food

**85d - Trash Receptacles (continued)**

and trash; however, neither trash was covered with a lid.

**Plan of Correction****Accept** [REDACTED] - 12/23/2025)

*Immediate Action: Upon discovering on 9/17/25 at approximately 9:15 a.m. that two kitchen trash cans were uncovered and half full, staff immediately placed lids on the receptacles, removed trash, and sanitized the area. Staff were reminded of requirements to keep trash covered. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: All trash receptacles in the kitchen and bathrooms were inspected, and missing or damaged lids were replaced. Updated procedures require staff to check lids throughout their shifts. Staff were retrained on §2600.85(d) trash disposal and sanitation requirements. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.*

*Preventative Action: A daily sanitation checklist was implemented to verify all trash receptacles remain covered, accompanied by weekly administrative walk-throughs. Annual sanitation and pest prevention training will reinforce compliance. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented** [REDACTED] - 03/27/2026)**87 - Lighting****32. Requirements**

2600.

87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

**Description of Violation**

On [REDACTED], at approximately 11:41 a.m., multiple light bulbs were inoperable in the front emergency exit stairwell, near the women's sunroom, on the first-floor landing, mid-floor landing, and the basement-floor landing and lighting was insufficient to ensure safe movement of residents through the home or safe evacuation.

On [REDACTED], at approximately 11:45 a.m., the approximately 14-foot square room, leading from the basement hallway to the fire door labeled [REDACTED] that was part of the egress route, did not have any lighting to ensure safe movement of residents or safe evacuation.

**Plan of Correction****Accept** [REDACTED] - 12/23/2025)

*Immediate Action: Upon discovering on 9/17/25 at approximately 11:41 a.m. that multiple light bulbs were inoperable along the emergency exit stairwell and adjacent areas, maintenance staff immediately installed working bulbs and restored adequate lighting. Temporary lighting was used during repairs. Administrator [REDACTED] the responsible party, will ensure completion of immediate actions by January 11, 2026.*

*Corrective Action: A full inspection of all evacuation routes was completed, and all nonfunctional fixtures were repaired or replaced. Maintenance procedures were updated to include routine lighting checks, and staff were*

**87 Lighting (continued)**

retrained on §2600.87 lighting requirements. Administrator [REDACTED] will ensure these corrective actions are completed by January 11, 2026.

*Preventative Action: Weekly lighting inspections of all emergency exits and stairwells were implemented, along with monthly administrative walk throughs. Annual training was added for maintenance and administrative staff on safe lighting standards. These preventative actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented [REDACTED] - 03/27/2026)

**88a - Surfaces****33. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

On [REDACTED], at approximately 10:45 a.m., the doorknob to the men's bathroom door on the main floor, across from room [REDACTED], was missing; leaving a hole, approximately 2 inches in diameter.

On [REDACTED], at approximately 10:51 a.m., the emergency exit door [REDACTED] on the first floor men's side, did not self close, as the door closer was not installed on this door.

On [REDACTED] at approximately 11:41 a.m., the exterior emergency exit door, closest to the women's sunroom, did not self close.

On [REDACTED] at approximately 11:45 a.m., the approximately 14 foot square room, leading from the basement hallway to the fire door labeled [REDACTED] contained crumbling ceiling debris that was lying on the floor in a 3 ft section near the threshold of the fire door, and there were multiple old green bed pillows lying on the floor near the other doorway close to the hallway, posing a potential trip hazard.

On [REDACTED], the basement was unlocked and fully accessible to residents. The following hazards were observed: broken glass on the floor in the room identified as the former morgue room, detached sinks, detached toilets, and pipes lying on the floor in open rooms of the basement.

On [REDACTED], the 2nd and 3rd floor did not have an occupancy permit and was fully accessible to residents. The following hazards were observed: crumbling drywall near the water fountain, parts of the flooring, in the hallway posing a potential trip hazard, floor/ceiling tiles stacked in the hallway, posing a potential trip hazard.

On [REDACTED] at approximately 10:00 a.m., live high voltage electrical wiring, in the basement boiler room in the south side of the building, was exposed and accessible to residents.

On [REDACTED], at approximately 11:06 a.m., an extension cord, powering a television, belonging to resident [REDACTED] and a box fan, belonging to resident [REDACTED] were all located on the floor in the bedroom between the far wall and across the floor between resident [REDACTED] and [REDACTED]'s bed, posing as a tripping hazard.

## 88a Surfaces (continued)

## Plan of Correction

Accept ( ) - 12/23/2025)

*Immediate Action: Upon identifying multiple environmental hazards on 9/17/25 including a missing bathroom doorknob, non self closing emergency exit doors, ceiling debris near fire door tripping hazards, exposed high voltage wiring, and unsafe resident areas such as the unlocked basement and unsecured upper floors the administrator, immediately restricted resident access to all unsafe areas. Maintenance staff were dispatched the same day to install temporary fixes, such as securing doors, removing debris, blocking off hazardous zones, covering exposed wiring, and removing tripping hazards from resident rooms. Staff were assigned to closely supervise residents to ensure no one entered unsafe locations during remediation. Administrator is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: Permanent repairs were completed, including installing a new doorknob on the men's bathroom door, installing or repairing door closers on emergency exits, repairing ceiling damage and removing debris, locking and securing the basement and any floors without occupancy permits, and addressing all identified structural hazards such as crumbling drywall, loose flooring, and abandoned fixtures. Licensed electricians corrected the exposed high voltage wiring to ensure compliance with safety standards. All resident rooms were inspected and cleared of extension cords or other tripping hazards not compliant with safety regulations. A comprehensive facility wide safety inspection was conducted to locate and correct any additional hazards. Staff were retrained on the requirement under §2600.88(a) to maintain all surfaces, doors, and environmental areas in good repair and free of hazards. These corrective actions will be completed under the responsibility of Administrator by January 11, 2026.*

*Preventative Action: The facility's administrator, implemented a weekly environmental safety audit of all floors, stairwells, exits, basements, and resident rooms to ensure ongoing compliance and early detection of hazards. The basement and any non occupied floors were added to restricted access protocols requiring locked doors and staff supervision. A formal maintenance reporting system was established to ensure immediate communication and swift correction of hazards. Maintenance and direct care staff will receive annual training on environmental safety, hazard recognition, and emergency exit requirements to prevent recurrence of these violations and ensure a continuously safe living environment for residents. Administrator will ensure all preventative actions are completed by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

## 89b - Hot Water Temperature

## 34. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

## Description of Violation

On at approximately 10:40 a.m., the water temperature at the sink in the unlocked and accessible single use bathroom labeled "Employee Washroom E", measured 128.2 degrees Fahrenheit.

## Plan of Correction

Accept ( ) - 12/23/2025)

*Immediate Action: Upon discovering on 9/17/25 at approximately 10:40 a.m. that the water temperature in the*

**89b Hot Water Temperature (continued)**

unlocked and accessible "Employee Washroom E" measured 128.2°F exceeding the maximum allowable temperature of 120°F the administrator, [REDACTED] immediately restricted resident access to the bathroom. Maintenance staff reduced the hot water temperature at the source and verified that all sinks accessible to residents were within safe limits. The bathroom remained locked until safe temperature levels were confirmed. Administrator [REDACTED] will ensure completion of these immediate actions by January 11, 2026.

**Corrective Action:** A full inspection of the home's hot water system was conducted to ensure all mixing valves and temperature regulators were functioning properly. Any faulty components were repaired or replaced. All bathrooms and resident accessible water sources were tested to confirm compliance with the 120°F maximum requirement. Staff were retrained on monitoring water temperatures, reporting temperature fluctuations, and ensuring restricted areas remain locked if water temperatures exceed safe limits. These corrective actions are the responsibility of Administrator [REDACTED] and will be completed by January 11, 2026.

**Preventative Action:** The home's administrator, [REDACTED] implemented a weekly hot water temperature monitoring log requiring maintenance or designated staff to check temperatures at all resident accessible faucets. Temperature checks will also occur after any plumbing or boiler adjustments. Annual maintenance training on water temperature safety and regulatory requirements under §2600.89(b) was added to the training plan. These preventative actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Implemented ( [REDACTED] - 03/27/2026)**

**93a - Handrails****35. Requirements**

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

**Description of Violation**

On [REDACTED], at approximately 11:41 a.m., the exterior step, leading from the exterior emergency exit door closest to the women's sunroom to the outside, did not have a handrail.

**Plan of Correction**

**Accept ( [REDACTED] - 12/23/2025)**

**Immediate Action:** Upon discovering on 9/17/25 at approximately 11:41 a.m. that the exterior step leading from the emergency exit closest to the women's sunroom lacked a required handrail, the administrator, [REDACTED] immediately restricted resident use of that exit and placed signage directing individuals to alternate, compliant exits. Staff were informed to prevent residents from using the area until the safety hazard was corrected. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

**Corrective Action:** Maintenance staff installed a well secured handrail that meets regulatory and safety standards for exterior steps as required by §2600.93(a). Once installed, the exit route was inspected to ensure it was safe for resident use, and access was reopened. A full inspection of all ramps, stairways, and outside steps throughout the home was completed to identify any additional handrail deficiencies, and any issues found were corrected. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.

**93a - Handrails (continued)**

*Preventative Action: The administrator, [REDACTED] implemented a quarterly environmental safety audit focused specifically on stairways, ramps, exits, and handrails to ensure all areas remain in compliance. Maintenance staff will receive annual training on handrail requirements, outdoor step safety, and environmental compliance standards. In addition, staff were instructed to report any missing, loose, or damaged handrails immediately to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ([REDACTED] - 03/27/2026)**

**96a - First Aid Kit****36. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

**Description of Violation**

On [REDACTED] the home's first aid kit did not include antiseptic, thermometer, and tweezers.

**Plan of Correction**

**Accept ([REDACTED] - 12/23/2025)**

*Immediate Action: Upon identifying on 9/17/25 that the home's first aid kit was missing required items—specifically antiseptic, a thermometer, and tweezers—staff immediately restocked the kit with these items. The administrator verified that the first aid kit was complete and accessible for emergency use in accordance with §2600.96(a). Staff were notified of the deficiency and instructed to report any missing or depleted items immediately. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: A full review of all first aid kits in the home was conducted to ensure each contained all items required by regulation, including nonporous gloves, adhesive bandages, gauze pads, adhesive tape, scissors, breathing shields, eye coverings, antiseptic, thermometer, and tweezers. An updated supply checklist was added to the first aid kit to guide proper restocking. Staff responsible for safety and emergency supplies were retrained on first aid kit requirements and proper documentation procedures. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.*

*Preventative Action: The administrator, [REDACTED] implemented a monthly first aid kit inspection log to ensure all kits remain fully stocked and compliant at all times. A designated staff member will be responsible for inspection, restocking, and documentation. Annual refresher training on first aid kit requirements and emergency preparedness will be provided to all direct care and supervisory staff to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ([REDACTED] - 03/27/2026)**

**101j4 - Bedroom Storage Area****37. Requirements**

**101j4 - Bedroom Storage Area (continued)**

2600.

101.j. Each resident shall have the following in the bedroom:

4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

**Description of Violation**

On [REDACTED], at approximately 11:06 a.m., resident [REDACTED] bedroom did not have a dresser.

On [REDACTED], at approximately 11:06 a.m., resident [REDACTED] bedroom did not have a dresser.

On [REDACTED], at approximately 11:29 a.m., resident [REDACTED] bedroom did not have a dresser.

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

*Immediate Action: Upon identifying on 9/17/25 that Residents [REDACTED] and [REDACTED] did not have dressers in their bedrooms as required by §2600.101(j), the administrator, [REDACTED] immediately provided temporary storage solutions, such as portable drawer units, to ensure residents had accessible clothing storage. Staff verified that each resident had a functional place to store personal items while permanent dressers were obtained. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: Permanent dressers were purchased and placed in the bedrooms of Residents [REDACTED] and [REDACTED] to meet the requirement for a chest of drawers and accessible clothing storage. A full inspection of all resident bedrooms was completed to ensure each room met furniture requirements. Staff responsible for room setup and admission preparation were retrained on §2600.101(j) to ensure all residents receive proper bedroom furnishings upon admission and on an ongoing basis. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.*

*Preventative Action: The home implemented a bedroom-furnishing checklist to be completed at admission and during quarterly room inspections. This checklist includes verification that each resident has a dresser, closet or wardrobe space, and all other required furnishings. Supervisors will conduct quarterly environmental audits to ensure compliance, and annual refresher training will be provided to staff to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented [REDACTED] - 03/27/2026)**

**101j5 - Bedside Table/Shelf****38. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

5. A bedside table or a shelf.

**Description of Violation**

On [REDACTED] at approximately 11:06 a.m., the bed belonging to resident [REDACTED] did not have a bedside table or shelf.

## 101j5 - Bedside Table/Shelf (continued)

**Plan of Correction**

Accept ( ) - 12/23/2025)

*Immediate Action: Upon discovering on 9/17/25 at approximately 11:06 a.m. that Resident [REDACTED] did not have a required bedside table or shelf, staff immediately provided a temporary bedside surface to ensure the resident had a safe and accessible place for personal items. The administrator, [REDACTED] verified that the temporary solution met the resident's immediate needs while a permanent bedside table was obtained. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: A permanent bedside table that meets regulatory requirements was purchased and placed next to Resident [REDACTED]'s bed. A full inspection of all resident bedrooms was conducted to ensure each resident had a bedside table or shelf in compliance with §2600.101(j). Staff responsible for room setup and environmental preparation were retrained on required bedroom furnishings and proper documentation of compliance. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.*

*Preventative Action: The administrator, [REDACTED] implemented a standardized bedroom-furnishing checklist to be completed at admission and reviewed during quarterly room inspections. Supervisors will conduct routine environmental audits to confirm that all required furnishings, including bedside tables or shelves, are present and in good condition. Annual refresher training for staff will reinforce regulatory requirements to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

Implemented ( ) - 03/27/2026)

## 101j7 - Lighting/Operable Lamp

**39. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

*On [REDACTED], at approximately 11:06 a.m., the bed belonging to resident [REDACTED] did not have a source of lighting that can be turned on/off from bedside.*

*On [REDACTED] at approximately 11:29 a.m., the bed belonging to resident [REDACTED] did not have a source of lighting that can be turned on/off from bedside, as the lamp was unplugged from the wall.*

**Plan of Correction**

Accept ( ) - 12/23/2025)

*Immediate Action: On 9/17/25, upon discovering that Resident [REDACTED] and Resident [REDACTED] did not have operable bedside lighting, staff immediately provided functional temporary lighting for each resident. Resident [REDACTED]'s lamp was promptly plugged in and tested to ensure it functioned properly, and Resident [REDACTED] was provided a temporary lamp to ensure both residents had safe, accessible lighting that could be turned on/off from bedside. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: Permanent bedside lighting that meets regulatory standards was installed for both residents. Staff conducted a full inspection of all resident bedrooms to verify that every resident had an operable bedside lighting*

**101j7 - Lighting/Operable Lamp (continued)**

source. Any lamps that were unplugged, nonfunctional, or missing were repaired, replaced, or properly connected. Staff were retrained on requirements under §2600.101(j), including ensuring that lighting is operable and accessible at all times. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.

*Preventative Action:* The home's administrator, [REDACTED] added "bedside lighting operability" to its environmental safety checklist, which must be reviewed at admission, monthly environmental rounds, and during quarterly audits. Maintenance and direct care staff will receive annual refresher training on required bedroom furnishings and safety standards. Supervisory staff will verify compliance during routine walk-throughs to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Not Implemented** ([REDACTED] - 03/27/2026)

**102e - Privacy - Doors/Partitions****40. Requirements**

2600.

102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

**Description of Violation**

On [REDACTED], at approximately 10:45 a.m., a hole, measuring approximately 2 inches in diameter, in the men's bathroom door on the main floor, across from room 105, was not providing total privacy of the showers within the bathroom.

**Plan of Correction**

**Accept** ([REDACTED] - 12/23/2025)

*Immediate Action:* On 9/17/25, at approximately 10:45 a.m., staff immediately restricted use of the men's bathroom across from room 105 to ensure residents' privacy and safety. A temporary privacy barrier was placed over the 2-inch hole in the door to prevent visibility into the shower area until permanent repairs could be completed. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

*Corrective Action:* A maintenance technician repaired the door by installing a proper door panel and hardware to fully eliminate the hole and restore complete privacy in accordance with §2600.102(e). All common and shared bathrooms were inspected to ensure that doors, partitions, and privacy features were fully intact and functioning. Staff received refresher guidance on promptly reporting any structural damage affecting resident privacy. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.

*Preventative Action:* The home's administrator, [REDACTED] added bathroom privacy checks to its weekly environmental safety inspections. Maintenance staff will conduct monthly audits of privacy features—including doors, partitions, and locks—to ensure they remain in good repair. Training for all staff now includes recognizing and reporting environmental concerns that compromise privacy, helping to prevent recurrence of similar violations. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Implemented** ([REDACTED] - 03/27/2026)

## 102e - Privacy - Doors/Partitions (continued)

## 103j - Utensils Cleaning

## 41. Requirements

2600.

103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

## Description of Violation

On [REDACTED], at approximately 11:00 a.m., 2 blue dinner plates with dried food were sitting on the folding table in the men's community room [REDACTED].

## Plan of Correction

Accept ( [REDACTED] ) - 12/23/2025)

Immediate Action: On 9/17/25 at approximately 11:00 a.m., staff immediately removed the two blue dinner plates with dried food from the folding table in the men's community room L-108. The plates were washed, rinsed, and sanitized according to the procedures outlined in 7 Pa. Code Chapter 46, Subchapter D. The area was cleaned and disinfected to ensure sanitary conditions. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

Corrective Action: All staff were reminded and reeducated by the administrator, [REDACTED] on the requirement that eating, drinking, and cooking utensils must be washed, rinsed, and sanitized after each use, and may not be left in common areas. A review of dish-handling procedures was conducted, and responsibility was clarified for ensuring all used items are promptly returned to the kitchen for proper cleaning. Supervisors completed a walkthrough of common areas to confirm no additional utensils or dishes were improperly stored. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.

Preventative Action: The facility's administrator, [REDACTED] implemented a daily common-area sweep checklist requiring staff to inspect for and remove any used utensils or food-related items. Dining and kitchen staff received refresher training on sanitation regulations under §2600.103(j) and 7 Pa. Code Chapter 46. Ongoing monthly audits by the administrator will verify compliance with dishwashing and sanitation procedures to prevent recurrence of similar violations. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented ( [REDACTED] ) - 03/27/2026)

## 105g - Lint Removal and Duct Cleaning

## 42. Requirements

2600.

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

## Description of Violation

On [REDACTED], at approximately 10:45 a.m., there was an accumulation of approximately ¼ inch of lint in the lint trap of the dryer on the men's side first floor.

**105g - Lint Removal and Duct Cleaning (continued)****Plan of Correction****Accept ( ) - 12/23/2025)**

*Immediate Action: On 9/17/25 at approximately 10:45 a.m., staff immediately removed the accumulation of approximately 1/4 inch of lint from the lint trap of the dryer on the men's side first floor. The surrounding area was inspected to ensure no additional lint buildup existed, and the dryer was taken out of use temporarily until staff confirmed it was safe to operate. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: The vent duct, internal, and external ductwork of the dryer were cleaned according to the manufacturer's guidelines to eliminate any additional fire hazards. All dryers in the home were inspected and cleaned as necessary to ensure compliance with §2600.105(g). Direct care and housekeeping staff were retrained on the requirement to remove lint after each use and to document lint trap cleaning. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.*

*Preventative Action: The administrator, [REDACTED] implemented a dryer maintenance log requiring staff to document lint removal after each load, with supervisory review at the end of each shift. Monthly maintenance checks were added to ensure vent ducts and ductwork remain free of buildup. Staff will receive annual training on fire-prevention practices related to laundry equipment to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Implemented ( ) - 03/27/2026)****107c - Food/Water 3 Day Supply****43. 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 [REDACTED] the home did not have a 3-day supply of nonperishable food.

On [REDACTED] the home was serving 12 residents requiring a minimum of 36 gallons of drinking water for a 3-day emergency supply. However, there were only 9.9 gallons of water on-site.

**Plan of Correction****Accept ( ) - 12/23/2025)**

*Immediate Action: On 9/17/25, upon discovering that the home did not have the required 3-day supply of nonperishable food and that only 9.9 gallons of drinking water were available instead of the required 36 gallons for 12 residents, the facility's administrator, [REDACTED] immediately purchased additional bottled water and essential nonperishable food items. Supplies were brought on-site the same day to ensure residents had adequate emergency provisions. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: A full inventory audit was completed, and a complete 3-day supply of both nonperishable food and drinking water was established and documented in compliance with §2600.107(c). Storage shelving was reorganized to clearly label and separate emergency supplies from daily-use items. Staff responsible for food service and inventory were retrained on emergency supply requirements, minimum quantities, and proper monitoring*

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

procedures. These corrective actions will be completed under the responsibility of Administrator [REDACTED] by January 11, 2026.

*Preventative Action:* The home administrator, [REDACTED] implemented a weekly emergency supply checklist to verify that the required 3 day supply of nonperishable food and drinking water is consistently maintained. Monthly administrator reviews and quarterly emergency preparedness audits were added to ensure ongoing compliance. Staff will receive annual refresher training on emergency supply standards and replenishment procedures to prevent recurrence of this violation. Administrator [REDACTED] will ensure all preventative actions are completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Not Implemented ( [REDACTED] - 03/27/2026)**

**121a - Unobstructed Egress****44. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], at approximately 11:30 a.m., the exterior emergency exit door, near room [REDACTED], leading to a large courtyard was secured with fencing that was topped with barbed wire. Additionally, there was a sign on the inside of the exit door that read "Do not go through this door without calling the shift desk".

On [REDACTED], at approximately 10:00 a.m., the maintenance room, located in the basement, was unlocked, accessible, and unattended. The exterior emergency exit door, inside the maintenance room, was padlocked shut from the inside of the home.

On [REDACTED], at approximately 10:10 a.m., the exit door from the basement opened to a covered driveway that was blocked at both ends with chain link fencing, posing an entrapment and blocked egress route.

**Plan of Correction**

**Accept ( [REDACTED] - 12/23/2025)**

*Immediate Action:* On 9/17/25 and 10/2/25, staff immediately removed residents from affected areas and ensured alternative safe egress routes were accessible. The maintenance room was secured to prevent resident access, and the padlock on the interior emergency exit door was removed. Staff also removed temporary signage restricting exit use and verified that all exit doors could be freely opened from the inside without obstruction. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

*Corrective Action:* All fencing, blockages, and the barbed wire restricting the courtyard exit and basement exit routes were removed to restore full, code compliant egress. A comprehensive inspection of all stairways, hallways, exit doors, and passageways was conducted to ensure they were unlocked and unobstructed in accordance with §2600.121(a). Maintenance and supervisory staff were retrained on proper egress safety standards, prohibited obstructions, and immediate reporting protocols. Updated procedures for securing maintenance areas without blocking exits were implemented. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

**121a - Unobstructed Egress (continued)**

*Preventative Action: The home administrator, [REDACTED] established weekly egress safety checks and monthly administrator-led building walkthroughs to verify all exit routes remain unlocked, accessible, and free of obstructions. An emergency egress compliance checklist was added to the maintenance department's daily duties. Annual staff training on evacuation and egress requirements—including identifying and preventing entrapment hazards—will be conducted to ensure ongoing compliance and prevent recurrence of these violations.*

*The administrator, [REDACTED] is responsible for completing these corrective actions by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ([REDACTED] - 03/27/2026)**

**123b - Emergency Procedures Posted****45. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], the home's emergency procedures were not posted in a conspicuous and public place in the home.

**Plan of Correction**

**Accept ([REDACTED] - 12/23/2025)**

*Immediate Action: On 9/17/25, once it was identified that the home's emergency procedures were not posted, the administrator, [REDACTED] immediately printed and temporarily posted a copy of the emergency procedures in a central, visible location accessible to all residents, visitors, and staff. Additional copies were also made available at the front desk to ensure immediate compliance. Administrator [REDACTED] is responsible for completing these immediate actions by January 11, 2026.*

*Corrective Action: A permanent, clearly displayed posting of the emergency procedures, as required under §2600.123(b), was installed in multiple conspicuous and public areas of the home, including near main entrances, dining areas, and common rooms. Staff conducted a full walkthrough to verify visibility and accessibility. All staff were retrained on the requirement to maintain posted emergency procedures and to report missing or damaged postings promptly. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action: The home added verification of properly posted emergency procedures to its monthly safety and environmental audits. Annual emergency preparedness training will reinforce posting requirements and staff responsibilities for maintaining compliance. A designated staff member will monitor posting locations weekly to ensure documents remain visible, intact, and up to date, preventing recurrence of this violation. Administrator, [REDACTED] will ensure these corrective actions will be completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ([REDACTED] - 03/27/2026)**

**130f - Testing Smoke Detectors**

**46. Requirements**

2600.

130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

**Description of Violation**

*The smoke detectors and fire alarms were not tested monthly since January 2025. Nor was there documentation maintained.*

**Plan of Correction****Accept ( ) - 12/23/2025)**

*Immediate Action: Upon discovering that smoke detectors and fire alarms had not been tested since January 2025, the administrator, [REDACTED] instructed staff to immediately conduct and document a full facility-wide test on all smoke detectors and fire alarm devices to confirm proper operability. Any units identified as needing batteries or repairs were addressed on the same day to restore full safety compliance. Administrator [REDACTED] will ensure these immediate actions are completed by January 11, 2026.*

*Corrective Action: A complete audit of all fire safety equipment was performed, and a new standardized monthly fire safety testing log was created to document dates, results, and staff responsible for testing in compliance with §2600.130(f). Staff responsible for safety inspections received retraining on proper testing procedures and required documentation practices. Missing or incomplete records were reconstructed to the extent possible with available information. Administrator [REDACTED] is responsible for ensuring completion of these corrective actions by January 11, 2026.*

*Preventative Action: The administrator, [REDACTED] implemented an automated reminder system and incorporated monthly smoke detector and fire alarm testing into its safety calendar and supervisor checklists. Quarterly administrative audits will verify that monthly tests are completed and properly documented. Annual fire-safety training for all staff will emphasize regulatory requirements and reinforce the importance of maintaining thorough written records to prevent recurrence of this violation. Completion of these corrective actions to be completed by administrator, [REDACTED] by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ( ) - 03/27/2026)****131c - Kitchen Fire Extinguisher****47. Requirements**

2600.

131.c. A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

**Description of Violation**

*On [REDACTED], at approximately 12:05 p.m., there was no fire extinguisher with minimum 2A-10BC rating in the main kitchen on the basement level.*

**Plan of Correction****Accept ( ) - 12/23/2025)**

*Immediate Action: On 9/17/25 at approximately 12:05 p.m., staff immediately placed a temporary fire extinguisher in the main kitchen on the basement level to ensure residents and staff had access to fire protection equipment. The area was checked to confirm no immediate fire hazards were present while awaiting installation of the required extinguisher. Administrator [REDACTED] will ensure these immediate actions are completed by January 11, 2026.*

**131c Kitchen Fire Extinguisher (continued)**

*Corrective Action: A fire extinguisher meeting the minimum 2A 10BC rating requirement was purchased and permanently installed in the main kitchen on the basement level in compliance with §2600.131(c). All fire extinguishers throughout the home were inspected to confirm proper placement, accessibility, and adequate ratings. Staff received refresher training on fire extinguisher requirements, inspection procedures, and reporting protocols for missing or deficient safety equipment. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action:*

*The home's administrator, [REDACTED] incorporated monthly fire safety equipment inspections into its maintenance and safety checklist, including verification of extinguisher presence, rating, and condition in required locations. Quarterly administrative audits will ensure ongoing regulatory compliance. Staff will receive annual training on fire safety equipment standards to prevent recurrence of this violation. Expected completion date of January 11, 2026*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Implemented ([REDACTED] - 03/27/2026)**

**132a - Monthly Fire Drill****48. Requirements**

2600.

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

**Description of Violation**

*A monthly unannounced fire drill was not conducted in March, April, June, July, August, and September of 2025.*

**Plan of Correction**

**Accept ([REDACTED] - 12/23/2025)**

*Immediate Action: Upon identifying that monthly unannounced fire drills were not conducted in March, April, June, July, August, and September 2025, the home's administrator, [REDACTED] immediately conducted an unannounced fire drill to ensure residents and staff practiced emergency evacuation procedures. Staff were reminded of the importance of monthly drills and the regulatory requirement for documentation. Administrator [REDACTED] is responsible for ensuring these immediate actions are completed by January 11, 2026.*

*Corrective Action: A full review of fire drill procedures and documentation practices was completed. A revised fire drill schedule was created for the remainder of the year to ensure compliance with §2600.132(a). Staff responsible for coordinating drills were retrained on planning, conducting, and documenting unannounced fire drills. Past documentation gaps were addressed, and all staff received refresher training on evacuation responsibilities and drill procedures. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action:*

*The facility's administrator, [REDACTED] implemented an automated monthly reminder system and added fire drills to the facility's regulatory compliance calendar. The administrator will complete monthly verification that each drill is conducted and logged, with quarterly audits to ensure accuracy and consistency. Annual emergency preparedness training for all staff will reinforce the requirement for monthly unannounced fire drills to prevent recurrence of this violation. Administrator, [REDACTED] is responsible for the completion of corrective actions by*

**132a - Monthly Fire Drill (continued)**

January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

**132b - Safety Inspection/Fire Drill****49. 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 home did not have a fire safety inspection and fire drill conducted by a fire safety expert.*

**Plan of Correction**

Accept ( ) - 12/23/2025)

*Immediate Action: The administrator, [REDACTED] will immediately contact a certified fire safety expert to schedule and complete both the overdue fire safety inspection and the required annual fire drill. Once completed, the home will obtain formal documentation of the inspection findings and the fire drill report. These documents will be filed on-site and made available to licensing staff upon request. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: Administrative staff will review existing safety procedures and update the home's compliance calendar to ensure the annual fire safety inspection and expert-led fire drill are formally tracked. Staff responsible for safety compliance will be retrained on regulatory requirement 2600.132(b) to ensure full understanding of documentation and scheduling expectations. All completed inspection and drill records will be stored in a designated compliance binder and electronically backed up. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

**Preventative Action:**

*The home's administrator, [REDACTED] will implement a recurring annual reminder system through to alert management 60 and 30 days before the due date of the next fire safety inspection and fire drill. A secondary reviewer will be assigned to verify completion and documentation each year. These steps will ensure consistent compliance with 2600.132(b) and prevent future lapses in required fire safety inspections and drills. Completion by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

**133.2 - Exit Signs Direction****50. Requirements**

2600.

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

**Description of Violation**

On [REDACTED], at approximately 11:52 a.m., there was no exit sign indicating the direction of travel in the hallway

**133.2 - Exit Signs Direction (continued)**

leading from the maintenance room to emergency exit door [REDACTED]

**Plan of Correction**

Accept [REDACTED] - 12/23/2025

*Immediate Action: On 9/17/25, immediately upon identifying the missing directional exit sign in the hallway leading from the maintenance room to emergency exit door [REDACTED] staff installed a temporary, clearly visible directional sign to ensure safe resident evacuation. A permanent, compliant exit sign was ordered the same day and installed within 24 hours. Staff verified that the exit route was clearly marked and unobstructed. Administrator [REDACTED] is responsible for ensuring these immediate actions are completed by January 11, 2026.*

*Corrective Action: Maintenance personnel reviewed all exit pathways throughout the home to confirm that every required exit sign and directional marker is present, visible, and compliant with regulation 2600.133(2). Any faded, improperly placed, or unclear signage was replaced. Staff responsible for environmental safety were retrained on exit visibility requirements and documentation procedures for monitoring signage. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

**Preventative Action:**

*The home's administrator, [REDACTED] will incorporate quarterly environmental safety audits that include inspection of all exit signs and directional markers. A preventive maintenance checklist will be updated to ensure that exit signage is routinely reviewed and replaced as needed. Additionally, management will require a secondary verification during monthly safety rounds to prevent future noncompliance with regulation 2600.133(2). Expected completion by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented [REDACTED] - 03/27/2026**

**141a 1-10 Medical Evaluation Information****51. 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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

**Description of Violation**

Resident [REDACTED] and [REDACTED] admitted on [REDACTED] did not have a medical evaluation completed.

**141a 1-10 Medical Evaluation Information (continued)**

Resident [REDACTED] medical evaluation, dated [REDACTED] indicates "see attached" for the medication section; however, nothing was attached. Additionally, the ability to self-administer medication section was blank.

**Plan of Correction****Accept ( [REDACTED] - 12/23/2025)**

*Immediate Action:* Medical evaluations for Residents [REDACTED] and [REDACTED] will be scheduled and completed immediately by a licensed physician, physician's assistant, or nurse practitioner to meet the requirements of regulation 2600.141(a). For Resident [REDACTED] the missing medication documentation and self-administration assessment will be obtained and completed immediately. All completed evaluations will be filed in each resident's record and reviewed for accuracy and completeness. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

*Corrective Action:* Staff responsible for resident intake and medical documentation will be retrained on the Department's required medical evaluation form and the specific elements outlined in 2600.141(a), including medication regimen and ability to self-administer. The home will review all current resident files to ensure compliance with required evaluations and documentation, correcting any incomplete or missing information. A verification checklist will be implemented to ensure that all new admissions have a complete evaluation within the required time frame. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

**Preventative Action:**

The administrator, [REDACTED] will implement a tracking system to monitor the due dates for initial and annual medical evaluations for all residents. Staff will conduct monthly audits of medical records to ensure all required information, including medication and self-administration assessments, is documented accurately. Any gaps will be addressed immediately to prevent future noncompliance with regulation 2600.141(a). Action to be completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ( [REDACTED] - 03/27/2026)****162c - Menus Posted****52. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], a menu, labeled Monday through Sunday was located in the main lobby of the home; however, the menu was not dated. A second menu, for the upcoming week, and an alternative menu was not posted in a conspicuous and public place in the home.

**Plan of Correction****Accept ( [REDACTED] - 12/23/2025)**

*Immediate Action:* On 9/17/25, the existing weekly menu was immediately updated to include the correct date for the current week. A second menu for the upcoming week and an alternative menu were prepared and posted in a

**162c Menus Posted (continued)**

conspicuous, public area of the home to ensure compliance with regulation 2600.162(c). Staff confirmed that all residents and visitors could easily access and view the menus. Administrator [REDACTED] is responsible for completion of these immediate actions by January 11, 2026.

*Corrective Action:* The dietary staff received retraining on the requirement to date weekly menus and post both the current and upcoming week's menus, along with any alternative menus, in a visible location. Procedures were updated to ensure menus are prepared and reviewed at least one week in advance. Documentation will be maintained to verify that menus are posted correctly each week. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

*Preventative Action:* A weekly checklist will be implemented by administrator, [REDACTED] to verify that menus are dated and posted for both the current and upcoming week, including alternative options. The dietary manager or designee will conduct routine audits each Monday to ensure compliance. This process will prevent future lapses in meeting the requirements of 2600.162(c) and ensure residents consistently have access to posted meal information. Completion of these corrective actions to be completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Implemented ( [REDACTED] - 03/27/2026)**

**183d - Prescription Current****53. Requirements**

2600.

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

**Description of Violation**

On [REDACTED] the following medications were in the cart, belonging to resident [REDACTED] however, this medication was not on the current medication administration record (MAR) nor did the home have a current order:

[REDACTED] after 1st loose stool and 1 tab after [REDACTED] as needed  
by mouth every day as needed for up to 10 doses.

**Plan of Correction**

**Accept ( [REDACTED] - 12/23/2025)**

*Immediate Action:* On 10/2/25, the medications for Resident [REDACTED] that were not on the current MAR and lacked a current order were immediately removed from the medication cart and securely stored separately. The administrator, [REDACTED] contacted the resident's prescribing provider to verify if a current order exists and obtained updated, accurate orders for all necessary medications. The MAR was updated to reflect only medications with valid orders. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

*Corrective Action:* All staff were retrained on regulation 2600.183(d), emphasizing that only medications with current, valid prescriptions or orders may be kept in the home and included on the MAR. The administrator, [REDACTED] conducted a full audit of all resident medications to ensure that no unauthorized medications remain and

**183d Prescription Current (continued)**

that all MARs are accurate and complete. Documentation procedures were reinforced to ensure timely updates whenever orders change. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

**Preventative Action:**

A monthly medication audit system will be implemented to review all medications in the home against the MAR and current orders. Any discrepancies will be corrected immediately, and findings will be documented. Additionally, staff will complete quarterly refresher training on proper medication storage documentation, and adherence to 2600.183(d) to prevent future occurrences. The administrator, [REDACTED] will be responsible for the completion of these actions by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Implemented ([REDACTED]) - 03/27/2026)

**185a - Implement Storage Procedures****54. Requirements**

2600.

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

**Description of Violation**

Resident [REDACTED] was prescribed [REDACTED] blood glucose three times daily S/S 70 140 0U, 141 180 2U, 181 220 4U, 221 260 6U, 261 300 8U, 301 340 10U, 341 400 12U, 401 500 14U, 501+ notify MD. On multiple dates and times, resident [REDACTED]'s blood glucose readings were recorded on the resident's Medication Administration Record (MAR); however, no blood glucose reading was recorded on the resident's glucometer to include:

| Date & Time       | MAR        |
|-------------------|------------|
| [REDACTED]        | [REDACTED] |
| 9/30/25 7:00 a.m. | 111        |

Additionally, blood glucose readings, belonging to resident [REDACTED] were not recorded accurately on the following dates and times:

| Date & Time | Glucometer | MAR        |
|-------------|------------|------------|
| [REDACTED]  | [REDACTED] | [REDACTED] |

**Plan of Correction**

Accept ([REDACTED]) - 12/23/2025)

**Immediate Action:** Upon discovery, qualified staff immediately reviewed Resident [REDACTED]'s blood glucose readings and verified all current levels using the glucometer. Any discrepancies between the MAR and actual readings were corrected, and the physician was notified of any abnormal readings requiring follow up. Staff ensured that all future blood glucose checks were accurately performed, recorded on the glucometer, and documented correctly on the MAR. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

**185a - Implement Storage Procedures (continued)**

*Corrective Action: All qualified staff were retrained on proper blood glucose monitoring, documentation procedures, and the correct use of the MAR to ensure alignment with actual glucometer readings. Administrator [REDACTED] conducted a full audit of Resident [REDACTED]'s blood glucose records for the previous month to verify accuracy and correct any inconsistencies. Staff were educated on the importance of timely recording and verification of readings to ensure safe medication dosing according to the resident's prescribed insulin protocol. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action: Administrator [REDACTED] will implement a daily verification process, where a second nurse or supervisor cross-checks glucometer readings against the MAR to ensure accuracy. A monthly audit of blood glucose documentation will be added to the home's quality assurance program to prevent recurrence. Additionally, nursing staff will receive quarterly refresher training on proper glucose monitoring, insulin administration, and MAR documentation to maintain ongoing compliance with regulation 2600.185(a). Administrator [REDACTED] is responsible for completion of these preventative actions by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ([REDACTED] - 03/27/2026)**

**185b - Medication Procedures****55. Requirements**

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in [REDACTED] room.

**Description of Violation**

*The home's "Accountability of medication and controlled Substances" policy stated controlled substances defined as scheduled 2,3, or 4 medications, will be counted and documented at each shift, with the count being documented by 2 staff members and a supervisor.*

*Resident [REDACTED] was prescribed [REDACTED]-take 1 tablet by mouth every 6 hours as needed. On [REDACTED] there were 2 blister packs of resident [REDACTED] remaining in the medication cart, one containing 21 pills and the other containing 30 pills. However, the home was not maintaining a narcotic count sheet for either of the 2 blister packs and staff interviews indicated that narcotics are not counted at the end of every shift.*

**Plan of Correction**

**Accept ([REDACTED] - 12/23/2025)**

*Immediate Action: On 10/2/25, the remaining [REDACTED] blister packs for Resident [REDACTED] were immediately inventoried, and a current narcotic count sheet was created for both packs. Staff conducted a full count of all controlled substances in the home, and the counts were verified by a second staff member and documented appropriately. Any discrepancies were reported and investigated according to policy. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

**185b - Medication Procedures (continued)**

*Corrective Action: All qualified staff were retrained on the home's "Accountability of Medication and Controlled Substances" policy, emphasizing the requirement for end-of-shift counts of scheduled 2, 3, and 4 medications, proper documentation, and supervisor verification. Procedures were reviewed and updated to ensure that controlled substances are consistently counted, recorded on narcotic sheets, and discrepancies are immediately addressed. The home also reinforced access limitations to medication storage areas to authorized personnel only. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action: A daily and end-of-shift audit process will be implemented, with a supervisor verifying that all controlled substances are counted, documented, and reconciled accurately. Monthly quality assurance reviews will monitor compliance with controlled substance procedures, and refresher training for staff will be conducted quarterly to ensure ongoing adherence to regulation 2600.185(b) and safe medication administration practices. Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Implemented ([REDACTED] - 03/27/2026)**

**186a - Authorized Prescriber****56. Requirements**

2600.

186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

**Description of Violation**

*Resident [REDACTED]'s Medication Administration Records (MAR) for September 2025 and October 2025 indicate that the resident is prescribed [REDACTED] sub-q at bedtime. The medication was administered to the resident on multiple dates to include the following [REDACTED] and [REDACTED]. However, on [REDACTED] the home did not have a current prescriber's order for resident [REDACTED].*

*Resident [REDACTED]'s MARs for September 2025 and October 2025 indicate that the resident is prescribed [REDACTED] blood glucose three times daily S/S 70-140=0U, 141-180=2U, 181-220=4U, 221-260=6U, 261-300=8U, 301-340=10U, 341-400=12U, 401-500=14U, 501+ notify MD. The medication was administered to the resident on multiple dates and times to include the following [REDACTED] and [REDACTED]. However, on [REDACTED], the home did not have a current prescriber's order for resident [REDACTED].*

**Plan of Correction**

**Accept ([REDACTED] - 12/23/2025)**

*Immediate Action: On 10/2/25, Administrator [REDACTED] immediately contacted the prescribing providers for Residents [REDACTED] and [REDACTED] to obtain current, valid orders for Lantus Solostar and Aspart, respectively. Medication administration for both residents was paused until the updated orders were received and verified. The MARs were updated to reflect only medications with current prescriber orders. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: All qualified staff were retrained on the requirement that prescription medications must have a current, written order from an authorized prescriber and that MARs must be regularly reviewed for accuracy. Administrator [REDACTED] conducted a full audit of all resident MARs to ensure all prescription medications had up-to-date orders. Procedures were updated to include verification of prescriber orders before administering any*

**186a - Authorized Prescriber (continued)**

medication. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

*Preventative Action:* The administrator, [REDACTED] will implement a tracking system to monitor the expiration dates of all prescription orders and alert staff when orders need renewal. A weekly review of MARs and prescriber orders will be conducted by the nursing supervisor to ensure compliance. Quarterly staff training on proper prescription management and documentation will be provided to prevent future lapses and maintain adherence to regulation 2600.186(a). Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date:** 01/11/2026

**Implemented ( ) - 03/27/2026)**

**187a - Medication Record****57. Requirements**

2600.

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

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

**Description of Violation**

Resident [REDACTED] September 2025 Medication Administration Record (MAR) indicates that resident [REDACTED] is prescribed [REDACTED] 100unit/M, blood glucose three times daily S/S 70-140=0U, 141-180=2U, 181-220=4U, 221-260=6U, 261-300=8U, 301-340=10U, 341-400=12U, 401-500=14U, 501+ notify MD. On multiple dates and times, a blood glucose reading was taken and insulin was administered; however, the units administered were not recorded at the time of administration for the month of September 2025 to include:

[REDACTED]

## 187a - Medication Record (continued)

**Plan of Correction**

Accept ( ) - 12/23/2025)

*Immediate Action: Upon identifying the missing insulin administration documentation for Resident [REDACTED] in September 2025, staff immediately reviewed the resident's blood glucose readings and confirmed the insulin doses that were administered. The MAR was updated to accurately reflect the correct units administered for all missed entries. Staff ensured that all future insulin doses are recorded in real time, including dose, date, time, and initials of the administering nurse. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: All qualified staff were retrained on proper MAR documentation requirements according to regulation 2600.187(a), emphasizing the need to record the dose administered, route, time, and staff initials at the time of administration. Administrator [REDACTED] conducted a complete audit of MARs for all residents receiving insulin to verify accuracy and completeness. Procedures were updated to include verification steps to ensure no medication is administered without immediate documentation. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action: Administrator [REDACTED] will implement a weekly review of MARs by a supervisory nurse to ensure all administered medications are properly documented. Any discrepancies will be addressed immediately, and findings will be recorded. Additionally, quarterly staff training will be conducted on accurate and timely medication administration documentation to prevent future lapses and maintain compliance with 2600.187(a). Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.*

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ( ) - 03/27/2026)

## 187d - Follow Prescriber's Orders

**58. Requirements**

2600.

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

**Description of Violation**

*Resident [REDACTED]'s October 2024 Medication Administration Record indicates the resident is prescribed [REDACTED] mg-take 3 tablets by mouth twice a day for schizophrenia; however, this medication was not administered on [REDACTED] at 8:00 p.m. as the medication was not available in the home.*

**Plan of Correction**

Accept ( ) - 12/23/2025)

*Immediate Action: On 10/1/25, upon identifying that Resident [REDACTED] was not available for the 8:00 p.m. dose, Administrator [REDACTED] immediately contacted the prescribing provider to notify them of the missed dose and obtain guidance for administration. The medication was promptly obtained from the pharmacy and administered according to the prescriber's instructions. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

**187d - Follow Prescriber's Orders (continued)**

*Corrective Action: All qualified staff and pharmacy staff were retrained on the importance of maintaining an adequate supply of all prescribed medications and following the prescriber's directions, as required by regulation 2600.187(d). Procedures were updated to include a daily inventory check of high-risk and scheduled medications to prevent missed doses. Staff were instructed to document any missed doses and actions taken to correct them. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action: Administrator [REDACTED] will implement a weekly medication inventory and reorder schedule to ensure all medications are available when needed. A supervisory nurse will verify inventory and compliance with prescriber orders during daily rounds. Quarterly training will be conducted for staff on proper medication management, including timely administration and adherence to prescriber instructions, to prevent future occurrences. Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.*

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented ([REDACTED] - 03/27/2026)**

**191 - Resident Right to Refuse****60. Requirements**

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

**Description of Violation**

*Resident [REDACTED] and [REDACTED] admitted [REDACTED] have not been educated on the residents' right to question or refuse medication if the resident believes that there may be a medication error.*

*Resident [REDACTED] admitted [REDACTED], has not been educated on the resident's right to question or refuse medication if the resident believes that there may be a medication error.*

**Plan of Correction**

**Accept ([REDACTED] - 12/23/2025)**

*Immediate Action: Immediately upon identification, Residents [REDACTED] [REDACTED] [REDACTED] and [REDACTED] were provided education on their right to question or refuse medications if they believe a medication error may occur. The education session included explanation of the process, their rights, and how to report concerns. Documentation of the education provided was completed in each resident's record. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.*

*Corrective Action: All qualified staff were retrained on regulation 2600.191 regarding resident education and the importance of informing residents of their rights related to medications. Procedures were updated to ensure that resident education on medication rights is conducted upon admission and documented accurately in the resident's record. Staff were instructed to review these rights with residents whenever new medications are prescribed or changes occur. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.*

*Preventative Action: The home's administrator, [REDACTED] will implement a quarterly review of resident records to ensure education on medication rights has been provided and documented for all residents. New admissions will receive this education as part of the orientation process, and staff will use a checklist to verify completion. Ongoing staff training will reinforce the importance of resident education to maintain compliance with 2600.191.*

**191 - Resident Right to Refuse (continued)**

Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ([REDACTED] - 03/27/2026)

**221c - Post Activity Calendar****61. Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

**Description of Violation**

On [REDACTED], the home did not have a weekly activity calendar posted in a public and conspicuous place in the home.

**Plan of Correction**

Accept ([REDACTED] - 12/23/2025)

Immediate Action: On 9/17/25, staff immediately created and posted the current weekly activity calendar in a conspicuous, public area of the home so that all residents and visitors could easily access it. Residents and staff were notified of the calendar's location to ensure awareness of upcoming activities. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

Corrective Action: Staff were retrained on regulation 2600.221(c) regarding the requirement to post a current weekly activity calendar in a visible location. Procedures were updated to include preparation and posting of the weekly calendar at least one week in advance. Staff were assigned responsibility for verifying the calendar is accurate and displayed each week. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

Preventative Action: A weekly checklist will be implemented to ensure that activity calendars are prepared, dated, and posted in a public area on schedule. Supervisory staff will conduct routine checks during weekly rounds to confirm compliance. Additionally, staff will receive quarterly refresher training on activity calendar posting requirements to prevent future lapses. Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented ([REDACTED] - 03/27/2026)

**224a - Preadmission Screen Form****62. Requirements**

2600.

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

**Description of Violation**

Resident [REDACTED] admitted [REDACTED], did not have a preadmission screening form completed until [REDACTED]

Resident [REDACTED] admitted [REDACTED] did not have a preadmission screening form completed until [REDACTED], and did not

**224a - Preadmission Screen Form (continued)**

include a determination that needs of the resident could be met by the services provided by the home.

Resident [REDACTED] admitted [REDACTED], did not have a preadmission screening form completed until [REDACTED]

**Plan of Correction**

Accept [REDACTED] - 12/23/2025)

Immediate Action: Upon discovery, preadmission screening forms for Residents [REDACTED] and [REDACTED] were immediately completed and included documentation verifying that the residents' needs could be met by the services provided by the home. The completed forms were filed in each resident's record and reviewed by the admissions coordinator for accuracy and compliance. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

Corrective Action: All admissions staff were retrained on regulation 2600.224(a), emphasizing the requirement that preadmission screenings must be completed within 30 days prior to admission and include a determination that the home can meet the resident's needs. Policies and procedures were updated to ensure timely completion and review of all preadmission screening forms before or immediately upon resident admission. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

Preventative Action: Administrator [REDACTED] will implement an admissions tracking system to monitor completion deadlines for all preadmission screening forms. Supervisory staff will review pending admissions daily to ensure forms are completed accurately and on time. Additionally, quarterly audits of admission records will be conducted to maintain ongoing compliance and prevent future delays. Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.

Licensee's Proposed Overall Completion Date: 01/11/2026

Not Implemented [REDACTED] - 03/27/2026)

**225a - Assessment 15 Days****63. Requirements**

2600.

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

**Description of Violation**

Resident [REDACTED] initial assessment dated [REDACTED] did not include an assessment of the resident's needs for the following: doing laundry, shopping, and ability to avoid/use poisonous materials, these sections of the form were marked as not applicable.

Resident [REDACTED]'s initial assessment dated [REDACTED], did not include an assessment of the resident's needs for the following: doing laundry, shopping, ability to avoid/use poisonous materials, using telephone, these sections of the form were marked as not applicable.

**225a - Assessment 15 Days (continued)**

Resident [REDACTED] initial assessment dated [REDACTED] did not include an assessment of the resident's needs for Hearing, Communication, Olfactory. This section of the form was blank.

Resident [REDACTED] initial assessment dated [REDACTED] did not include an assessment of the resident's needs for the following: doing laundry, shopping, ability to use/avoid poisonous materials, using the telephone and managing finances, these sections of the form were marked as not applicable. However, the resident requires assistance of a family member to manage finances.

**Plan of Correction****Accept [REDACTED] - 12/23/2025)**

Immediate Action: Upon identification, the initial assessments for Residents [REDACTED] and [REDACTED] were immediately reviewed and updated to include all required areas, including laundry, shopping, telephone use, managing finances, ability to avoid/use poisonous materials, and sensory needs (hearing, communication, olfactory). The updated assessments were completed by the administrator/designee and placed in each resident's record. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

Corrective Action: All staff responsible for completing initial assessments were retrained on regulation 2600.225(a) and the importance of completing every section of the Department's assessment form accurately within 15 days of admission. Procedures were revised to include a verification checklist to ensure no required assessment areas are marked "not applicable" unless truly inapplicable, and that any assistance needs are clearly documented. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

Preventative Action: Administrator [REDACTED] will implement a system of supervisory review for all new resident assessments to ensure completeness and accuracy within the 15-day timeframe. Monthly audits will be conducted to verify compliance, and staff will receive quarterly refresher training on completing initial assessments in accordance with Department requirements to prevent future omissions. Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date: 01/11/2026**

**Not Implemented [REDACTED] - 03/27/2026)****227d - Support Plan Medical/Dental****64. 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 [REDACTED] initial assessment, dated [REDACTED], indicated medical diagnoses of [REDACTED], and [REDACTED]. Resident [REDACTED] was also assessed as being unable to self-administer medications having minimal problems with short-term and long-term memory. The initial support plan dated [REDACTED], was blank in these areas.

Resident [REDACTED] initial assessment, dated [REDACTED], indicated medical diagnoses of [REDACTED], [REDACTED], [REDACTED]. However, the initial support plan, dated [REDACTED], indicated

**227d - Support Plan Medical/Dental (continued)**

"monitor by staff" as the plan to meet these resident needs.

Resident [REDACTED]'s initial assessment, dated [REDACTED], indicated medical diagnoses of [REDACTED], [REDACTED], and [REDACTED]. Resident [REDACTED] was also assessed as requiring some physical assistance with eating, drinking, transferring in/out of bed/chair, toileting, bladder management, ambulating, personal hygiene, managing health care, securing health care, turning and positioning in bed/chair, and requires total physical assistance with bowel management, doing laundry, securing and using transportation, managing finances, making and keeping appointments. The initial support plan, dated [REDACTED], was blank in these areas.

**Plan of Correction****Accept ( [REDACTED] - 12/23/2025)**

*Immediate Action:* Upon identification, the initial support plans for Residents [REDACTED], [REDACTED], and [REDACTED] were immediately updated to include all medical diagnoses, functional needs, and assistance requirements as identified in their initial assessments. Staff documented specific interventions and supports to address each resident's medical, mental health, and behavioral care needs. The updated support plans were reviewed and placed in each resident's record for immediate use by care staff. Administrator [REDACTED] is responsible for ensuring completion of these immediate actions by January 11, 2026.

*Corrective Action:* All staff responsible for developing resident support plans were retrained on regulation 2600.227(d) to ensure that medical, dental, vision, hearing, mental health, and other behavioral care services are accurately reflected in the support plan. Procedures were revised to require a direct cross-check between the initial assessment and the support plan, ensuring that all identified resident needs are addressed with specific care interventions rather than general instructions. Administrator [REDACTED] is responsible for ensuring these corrective actions are completed by January 11, 2026.

*Preventative Action:* Administrator [REDACTED] will implement a supervisory review process for all new resident support plans to ensure completeness and alignment with initial assessments within 15 days of admission. Monthly audits will be conducted to verify that all resident needs are documented and that appropriate interventions or referrals are included. Staff will receive quarterly refresher training on proper support plan development to maintain compliance with 2600.227(d) and ensure residents receive individualized care. Administrator [REDACTED] is responsible for ensuring these preventative actions are completed by January 11, 2026.

**Licensee's Proposed Overall Completion Date: 01/11/2026****Not Implemented ( [REDACTED] - 03/27/2026)**

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

**Facility Information**

**Name:** NEW BRIGHTON PERSONAL CARE HOME      **License #:** 45604      **License Expiration:** 03/05/2026  
**Address:** 701 PENN AVENUE, NEW BRIGHTON, PA 15066  
**County:** BEAVER      **Region:** WESTERN

**Administrator**

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

**Legal Entity**

**Name:** AM RAFI, P.C.  
**Address:** [REDACTED]  
**Phone:** [REDACTED]      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

|                     |                         |                                           |
|---------------------|-------------------------|-------------------------------------------|
| <b>Type:</b> Other  | <b>Date:</b> 03/22/2024 | <b>Issued By:</b> Borough of New Brighton |
| <b>Type:</b> C 2 LP | <b>Date:</b> 03/08/1985 | <b>Issued By:</b> Dept L & I              |
| <b>Type:</b> Other  | <b>Date:</b> 08/02/1991 | <b>Issued By:</b> Dept L & I              |

**Staffing Hours**

**Resident Support Staff:** 0      **Total Daily Staff:** 25      **Waking Staff:** 19

**Inspection Information**

**Type:** Partial      **Notice:** Unannounced      **BHA Docket #:**  
**Reason:** Monitoring      **Exit Conference Date:** 02/04/2026

**Inspection Dates and Department Representative**

01/22/2026 On Site: [REDACTED]  
01/23/2026 On Site: [REDACTED]  
02/04/2026 On Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 68      **Residents Served:** 21

**Secured Dementia Care Unit**

**In Home:** No      **Area:**      **Capacity:**      **Residents Served:**

**Hospice**

**Current Residents:** 2

**Number of Residents Who:**

|                                                 |                                                  |
|-------------------------------------------------|--------------------------------------------------|
| <b>Receive Supplemental Security Income:</b> 11 | <b>Are 60 Years of Age or Older:</b> 14          |
| <b>Diagnosed with Mental Illness:</b> 7         | <b>Diagnosed with Intellectual Disability:</b> 2 |
| <b>Have Mobility Need:</b> 4                    | <b>Have Physical Disability:</b> 0               |

## Inspections / Reviews

01/22/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *03/01/2026*

04/20/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/02/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Bypass Document  
Submission*

04/21/2026 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: *04/20/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

## 25b SOPa - Rent Rebate: Contract

## 1. Requirements

2600.

25b.a. The resident-home contract is to include whether the home collects a portion of a resident's rent rebate under § 2600.25(d) (relating to resident-home contract).

## Description of Violation

*The resident-home contract, for resident [REDACTED] admitted [REDACTED], did not indicate whether the home collects a portion of the resident's rent rebate benefit.*

## Plan of Correction

Accept ( [REDACTED] - 03/10/2026)

## Immediate Action:

*Upon identification of the violation regarding § 2600.25(d), the Administrator, [REDACTED] immediately initiated a review of the resident-home contract for Resident [REDACTED] admitted 5/2/25. The contract was amended to explicitly state whether the home collects a portion of the resident's rent rebate benefit, in full compliance with regulatory requirements. The revised contract was reviewed with the resident and/or the resident's legal representative, signatures were obtained to acknowledge the update, and this action was completed on or before March 8, 2026.*

## Corrective Action:

*Administrator [REDACTED] conducted a comprehensive audit of all current resident-home contracts to ensure each agreement specifies whether the home collects any portion of a resident's rent rebate benefit, as required under § 2600.25(d). Any identified deficiencies were corrected through contract amendments, with documentation of resident and/or legal representative acknowledgment maintained in each resident record. All corrective actions were completed on or before March 31, 2026.*

## Preventative Action:

*Administrator [REDACTED] revised the facility's resident-home contract template to permanently include standardized language addressing rent rebate collection in accordance with § 2600.25(d). In addition, a policy review and staff training were implemented to ensure ongoing compliance with resident-home contract requirements. The contract review process was incorporated into the admission checklist to prevent recurrence of this violation. These preventative measures were fully implemented on or before March 31, 2026.*

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( [REDACTED] - 04/20/2026)

## 54a - Direct Care Staff

## 2. Requirements

2600.

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

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

## Description of Violation

*Direct Care Staff Person A, hired [REDACTED], did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.*

## 54a Direct Care Staff (continued)

## Plan of Correction

Accept ( ) - 03/10/2026)

## Immediate Action:

Upon identification of the violation of § 2600.54(a), Administrator [REDACTED] immediately removed Direct Care Staff Person A, hired 11/21/25, from the work schedule pending verification of qualifications. The employee's personnel file was reviewed to determine compliance with the requirement to possess a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. If qualification documentation could not be produced, employment was terminated in accordance with regulatory requirements. This immediate action will be completed on or before March 8, 2026.

## Corrective Action:

Administrator [REDACTED] conducted a comprehensive audit of all direct care staff personnel files to ensure compliance with § 2600.54(a)(1) (3), including verification of age, educational credentials or active nurse aide registry status, and documentation of freedom from medical conditions that would limit the provision of care. Any identified deficiencies were corrected through immediate removal from duty until compliant documentation was obtained or through termination of employment, as applicable. All corrective actions will be completed on or before March 31, 2026.

## Preventative Action:

Administrator [REDACTED] revised the facility's hiring and onboarding procedures to require verification and documented proof of a high school diploma, GED, or active Pennsylvania nurse aide registry status prior to the first day of work. A pre employment checklist was implemented to ensure all qualifications under § 2600.54(a) are verified and documented before scheduling staff to provide direct care. The Administrator also provided training to supervisory staff responsible for hiring to ensure ongoing compliance. These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

## 63a - First Aid/CPR Training

## 3. 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

On multiple dates and times, 20 residents were present in the home; however, there were no staff present in the home that were certified in first aid and obstructed airway techniques or CPR, to include:

On [REDACTED], from 11:00 p.m. to 7:00 a.m.

On [REDACTED] from 11:00 p.m. to 7:00 a.m.

On [REDACTED] from 3:00 p.m. to 7:00 a.m.

## Plan of Correction

Accept ( ) - 03/10/2026)

## Immediate Action:

Upon identification of the violation of § 2600.63(a), Administrator [REDACTED] immediately reviewed the staffing schedules for 1/17/26, 1/18/26, and 1/19/26 and confirmed that no staff person trained in first aid and certified in obstructed airway techniques and CPR was present in the home during the cited timeframes. Effective immediately,

**63a First Aid/CPR Training (continued)**

scheduling procedures were adjusted to ensure that at least one staff person currently certified in first aid, obstructed airway techniques, and CPR is present in the home at all times when residents are in care. Verification of current certification for scheduled staff was completed prior to assignment. This immediate action to be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] conducted a comprehensive review of all direct care staff training records to verify current certification in first aid, obstructed airway techniques, and CPR. Staff lacking current certification were scheduled for and completed approved training, and documentation of certification was placed in each personnel file. Staffing schedules were audited to ensure compliance with the requirement of at least one certified staff person per 50 residents present in the home at all times. All corrective actions will be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] implemented a tracking system to monitor certification expiration dates for first aid, obstructed airway techniques, and CPR to ensure timely renewal prior to lapse. The staffing coordinator was instructed that no shift may be scheduled without confirmation that at least one properly certified staff person is assigned. Policy was revised to require quarterly audits of staffing schedules and training records to ensure ongoing compliance with § 2600.63(a). These preventative measures to be fully implemented on or before March 31, 2026.

**Licensee's Proposed Overall Completion Date:** 03/31/2026

**Not Implemented ( [REDACTED] - 04/20/2026)**

**65a - FS Orientation 1st Day****4. Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

Staff person A, hired [REDACTED] did not complete orientation training on the following topics:

Evacuation procedures

Staff duties and responsibilities during fire drills

Staff person B, hired [REDACTED], did not complete any orientation training.

**65a - FS Orientation 1st Day (continued)**

Staff person C, hired [REDACTED] did not complete any orientation training.

**Plan of Correction**

Accept [REDACTED] - 03/10/2026)

*Immediate Action:*

Upon identification of the violation of § 2600.65(a), Administrator [REDACTED] immediately removed Staff Person A (hired 11/21/25), Staff Person B (hired 11/25/25), and Staff Person C (hired 7/13/25) from direct care duties pending completion of required orientation training. An immediate orientation session was conducted to include, at minimum, evacuation procedures; staff duties and responsibilities during fire drills and emergency evacuation; designated meeting place; smoking safety procedures and policy; location and use of fire extinguishers; smoke detectors and fire alarms; and telephone use and notification of emergency services. Documentation of completed orientation was placed in each personnel file. This immediate action will be completed on or before March 8, 2026.

*Corrective Action:*

Administrator [REDACTED] conducted a comprehensive audit of all direct care staff, ancillary staff, substitute personnel, and volunteer files to verify completion of orientation training in accordance with § 2600.65(a)(1)-(7) prior to or during the first work day. Any staff found to have incomplete or missing documentation were required to complete the full orientation training, and written verification was maintained in their personnel records. All corrective actions, including file updates and staff retraining as necessary, to be completed on or before March 31, 2026.

*Preventative Action:*

Administrator [REDACTED] revised the facility's onboarding procedures to require documented completion of orientation training prior to assignment to any shift providing direct care or services within the home. A standardized orientation checklist reflecting all required components of § 2600.65(a) was implemented and incorporated into the hiring packet. The Administrator will conduct periodic audits of new hire files to ensure ongoing compliance. These preventative measures to be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented [REDACTED] - 04/20/2026)

**65b - Rights/Abuse 40 Hours****5. 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).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

Staff person A, hired [REDACTED], did not complete orientation training on the following topics:

Mandatory reporting of abuse and neglect under OAPSA

Reporting of reportable incidents and conditions

**65b - Rights/Abuse 40 Hours (continued)**

Staff person B, hired [REDACTED], did not receive any orientation training.

Staff person C, hired [REDACTED] did not receive any orientation training.

**Plan of Correction****Accept [REDACTED] - 03/10/2026)****Immediate Action:**

Upon identification of the violation of § 2600.65(b), Administrator [REDACTED] immediately reviewed the personnel file of Staff Person A, hired 11/21/25, and confirmed that orientation training within 40 scheduled working hours did not include mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (OAPSA) and reporting of reportable incidents and conditions. Staff Person A was promptly scheduled for and completed the required training addressing resident rights, the emergency medical plan, mandatory reporting under OAPSA (35 P.S. §§ 10225.101—10225.5102), and reporting procedures for reportable incidents and conditions. Documentation of completion was placed in the personnel file. This immediate action to be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] conducted a comprehensive audit of all direct care staff, ancillary staff, substitute personnel, and volunteer files to verify completion of orientation training within 40 scheduled working hours as required under § 2600.65(b)(1)–(4). Any staff identified as having incomplete orientation training were required to complete the full orientation curriculum, and documentation of completion was maintained in each personnel record. All corrective measures will be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] revised the facility's orientation tracking system to ensure that all required topics under § 2600.65(b) are completed and documented within 40 scheduled working hours of hire. A standardized orientation checklist, inclusive of mandatory reporting under OAPSA and reporting of reportable incidents and conditions, was implemented and incorporated into the onboarding process. Ongoing monitoring through periodic personnel file audits will be conducted to ensure continued compliance. These preventative measures will be fully implemented on or before March 31, 2026.

**Licensee's Proposed Overall Completion Date: 03/31/2026**

**Not Implemented [REDACTED] - 04/20/2026)****82a - Poisonous Materials****6. Requirements**

2600.

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

**Description of Violation**

On [REDACTED] a spray bottle containing a green liquid was labelled "Zep"; however, this poison was not stored in the original, labeled container.

## 82a - Poisonous Materials (continued)

## Plan of Correction

Accept ( ) - 03/10/2026)

## Immediate Action:

Upon identification of the violation of § 2600.82(a) on 1/22/26, Administrator [REDACTED] immediately removed the spray bottle labeled "Zep" containing a green liquid from use and secured the substance. The contents were discarded in accordance with manufacturer guidelines and facility policy, as the product was not stored in its original, labeled container. Staff were immediately instructed that poisonous materials must remain in their original, labeled containers at all times. This immediate corrective measure will be completed on or before March 8, 2026.

## Corrective Action:

Administrator [REDACTED] conducted a comprehensive inspection of all storage areas within the home to ensure that all poisonous and hazardous materials are maintained in their original, labeled containers in compliance with § 2600.82(a). Any additional improperly stored substances identified during the inspection were removed, properly discarded, or returned to their original containers as applicable. Documentation of the inspection and corrective measures was maintained. All corrective actions to be completed on or before March 31, 2026.

## Preventative Action:

Administrator [REDACTED] revised facility procedures regarding the storage and handling of poisonous materials to clearly prohibit transferring such substances into secondary containers unless permitted by regulation and properly labeled in accordance with manufacturer and regulatory standards. Staff training was conducted to reinforce compliance with § 2600.82(a), and routine monthly environmental inspections were implemented to monitor ongoing adherence. These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

## 84 - Heat Sources

## 7. Requirements

2600.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

## Description of Violation

On [REDACTED], at approximately 12:20 p.m., an exposed pipe on the heating unit measured 160.5 degrees Fahrenheit and was unlocked, unattended, and accessible in the basement boiler room.

## Plan of Correction

Accept ( ) - 03/10/2026)

## Immediate Action:

Upon identification of the violation of § 2600.84 on 1/22/26 at approximately 12:20 p.m., Administrator [REDACTED] immediately restricted resident access to the basement boiler room by securing the area and ensuring it remained locked and unattended by residents. The exposed heating pipe measuring 160.5 degrees Fahrenheit was promptly insulated and fitted with an appropriate protective guard to prevent resident contact. Verification was completed to ensure the heat source was no longer accessible without protection. This immediate corrective action will be completed on or before March 8, 2026.

**84 - Heat Sources (continued)****Corrective Action:**

Administrator [REDACTED] conducted a comprehensive environmental inspection of the entire facility to identify any additional heat sources exceeding 120° F that may be accessible to residents. Any identified pipes, radiators, hot water heaters, or related equipment were equipped with protective guards or insulation as required by § 2600.84. Documentation of temperature checks, corrective measures, and maintenance actions was maintained on file. All corrective actions will be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] revised the facility's maintenance and environmental safety policy to require routine monitoring of heat sources, including periodic temperature checks and verification of proper guarding or insulation. Monthly environmental safety rounds were implemented to ensure ongoing compliance with § 2600.84. Maintenance staff were educated on regulatory requirements related to heat source protection to prevent recurrence. These preventative measures will be fully implemented on or before March 31, 2026

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ([REDACTED] - 04/20/2026)

**85a - Sanitary Conditions****8. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On [REDACTED], at approximately 10:00 a.m., a small puddle of a yellowish substance was observed on the floor, to the right of the toilet, in the Men's bathroom A, next to room [REDACTED]. Additionally, there was brown stains smeared on the back of the toilet seat.

**Plan of Correction**

Accept ([REDACTED] - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.85(a) on 1/22/26 at approximately 10:00 a.m., Administrator [REDACTED] immediately directed housekeeping staff to clean and disinfect the Men's Bathroom A, next to Room 112, including removal of the yellowish substance observed on the floor and the brown stains on the back of the toilet seat. The affected surfaces were sanitized using approved disinfectant in accordance with facility infection control procedures. The bathroom was inspected following cleaning to ensure sanitary conditions were restored. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] conducted a review of housekeeping schedules, cleaning logs, and supervision practices to ensure bathrooms and common areas are cleaned and monitored at a frequency sufficient to maintain sanitary conditions in compliance with § 2600.85(a). Staff responsible for environmental services were retrained on cleaning protocols, documentation requirements, and timely response to observed unsanitary conditions. All corrective measures, including staff retraining and implementation of enhanced monitoring, to be completed on or before March 31, 2026.

**85a Sanitary Conditions (continued)****Preventative Action:**

Administrator [REDACTED] implemented a revised environmental monitoring system requiring routine inspections of resident bathrooms and common areas throughout each shift, with documentation maintained in a sanitation log. Supervisory staff will conduct periodic audits to ensure compliance with sanitation standards and address deficiencies promptly. Ongoing oversight will be maintained to ensure continued compliance with § 2600.85(a). These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ([REDACTED] - 04/20/2026)

**88a - Surfaces****11. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

On [REDACTED], the following areas were unlocked, unattended, and accessible to residents:

At approximately 11:35 a.m., the bottom of the emergency stairwell, near the fire door labeled [REDACTED] contained crumbling debris from the ceiling that was lying on the floor of the stairwell.

At approximately 11:35 a.m., the beauty salon floor, located in the basement, contained a pile of laminate flooring; posing a trip hazard.

At approximately 11:35 a.m., the tile floor below the set of double doors, near the men's and ladies bathroom had several tiles that are shattered and strewn on the floor; posing a trip/fall hazard.

Storage room 6 in the basement has dozens of 2x4 and 2x6 pieces of wood piled on the floor with exposed screw tips.

A drop ceiling tile in the sunroom on the ladies' side, labeled 92, is building downward leaving a gap, approximately 3 inches in the middle.

**Plan of Correction**

Accept ([REDACTED] - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.88(a) on 1/22/26 at approximately 11:35 a.m., Administrator [REDACTED] immediately restricted resident access to the identified hazardous areas, including the emergency stairwell near fire door [REDACTED] the basement beauty salon, the area below the double doors near the men's and ladies' bathrooms, Storage Room 6, and the sunroom on the ladies' side labeled 92. Maintenance staff promptly removed ceiling debris, cleared and secured laminate flooring materials, removed shattered tiles and isolated the affected

**88a - Surfaces (continued)**

floor area, organized and secured lumber with exposed screws, and stabilized or replaced the sagging ceiling tile. All areas were cleaned and rendered safe for resident access. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] conducted a comprehensive environmental inspection of the entire facility to identify any additional conditions in which floors, walls, ceilings, windows, doors, or other surfaces were not in good repair or presented potential hazards. Necessary repairs were completed, including permanent replacement of damaged tiles, ceiling materials, and any structural or surface deficiencies identified. Documentation of inspections, repairs, and maintenance activities was maintained on file. All corrective measures to be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] implemented a routine environmental safety rounding process requiring documented weekly inspections of all resident-accessible areas to ensure surfaces remain clean, in good repair, and free of hazards in compliance with § 2600.88(a). Maintenance request procedures were reinforced to ensure timely reporting and correction of identified issues. Supervisory oversight was enhanced to monitor completion of repairs and prevent recurrence. These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( [REDACTED] - 04/20/2026)

**96a - First Aid Kit****12. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

**Description of Violation**

On [REDACTED], the home's first aid kit did not include antiseptic and a thermometer. The second first aid kit provided did not include a thermometer.

**Plan of Correction**

Accept ( [REDACTED] - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.96(a) on 1/22/26, Administrator [REDACTED] immediately inspected all first aid kits within the home and confirmed that required items, including antiseptic and a thermometer, were missing. The deficient supplies were promptly obtained and placed into both first aid kits to ensure inclusion of all required components: nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, and tweezers. Each kit was inventoried to verify completeness. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] conducted a comprehensive review of all emergency and medical supplies maintained within the facility to ensure full compliance with § 2600.96(a). was developed and utilized to verify completeness of each kit. Documentation of the inventory review and restocking process was maintained on file. All corrective measures will be completed on or before March 31, 2026.

## 96a - First Aid Kit (continued)

*Preventative Action:*

Administrator [REDACTED] implemented a monthly first aid kit inspection protocol requiring documented verification that all required items remain present, intact, and within expiration dates. Responsibility for routine inspection and restocking was assigned to designated staff, with supervisory oversight to ensure compliance. These preventative measures to be fully implemented on or before March 31, 2026, to ensure ongoing compliance with § 2600.96(a).

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ([REDACTED] - 04/20/2026)

## 107c - Food/Water 3 Day Supply

## 13. 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 [REDACTED] the home did not have a 3-day supply of nonperishable food.

On [REDACTED], the home was serving 20 residents requiring a minimum of 60 gallons of drinking water for a 3-day emergency supply. However, there were only 36.96 gallons of water on-site.

**Plan of Correction**

Accept ([REDACTED] - 03/10/2026)

*Immediate Action:*

Upon identification of the violation of § 2600.107(c) on 1/22/26, Administrator [REDACTED] immediately conducted an inventory of the home's emergency food and water supply. Additional nonperishable food items sufficient to meet a minimum three-day supply for 20 residents were promptly purchased and secured on-site. Drinking water was increased to meet and exceed the required minimum of 60 gallons for a three-day emergency supply. Documentation of purchases and inventory verification was maintained. This immediate corrective action to be completed on or before March 8, 2026.

*Corrective Action:*

Administrator [REDACTED] implemented a comprehensive review of the facility's emergency preparedness plan to ensure accurate calculation and maintenance of required food and water supplies based on census. Emergency food and water supply procedures were revised to clearly outline minimum quantity requirements, storage locations, rotation practices, and staff responsibilities for maintaining compliance. All supplies were organized, labeled, and dated to ensure accessibility and proper rotation. All corrective measures will be completed on or before March 31, 2026.

*Preventative Action:*

Administrator [REDACTED] established a monthly emergency supply review process to verify continued compliance with the requirement to maintain at least a three-day supply of nonperishable food and drinking water for the current resident census. Procedures were implemented to require immediate replenishment when census increases or supplies fall below required thresholds. Staff responsible for oversight were educated on regulatory

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

requirements under § 2600.107(c). These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

**132a - Monthly Fire Drill****14. Requirements**

2600.

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

**Description of Violation**

A monthly unannounced fire drill was not conducted in October, November, or December of 2025.

**Plan of Correction**

Accept ( ) - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.132(a), Administrator ( ) immediately scheduled and conducted an unannounced fire drill to reestablish compliance with the requirement that drills be held at least once a month. Documentation of the drill included date, time, staffing, resident participation, evacuation time, and identified areas for improvement. Staff were reminded of the requirement that fire drills must be conducted monthly and remain unannounced. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator ( ) conducted a review of the facility's fire drill documentation for calendar year 2025 and confirmed the absence of drills for October, November, and December 2025. The fire drill schedule was revised to ensure drills are pre-planned for each month of the calendar year while remaining unannounced to staff and residents. Documentation procedures were reviewed and reinforced to ensure each drill is properly recorded and maintained on file. All corrective measures to be completed on or before March 31, 2026.

**Preventative Action:**

Administrator ( ) implemented a compliance monitoring system requiring advance calendar scheduling and administrative oversight to ensure an unannounced fire drill is conducted at least once per month in accordance with § 2600.132(a). Responsibility for tracking drill completion was assigned to the Administrator, with quarterly internal audits to verify ongoing compliance. These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

**182b - Prescription Medication****15. Requirements**

2600.

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

**182b Prescription Medication (continued)**

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**

Staff person D, administered multiple medications to multiple residents on [REDACTED] at 8:00 p.m., to include the following; however, this staff person had no medication administration training:

Resident [REDACTED]

Resident [REDACTED]

Staff person E, administered multiple medications to multiple residents on the following dates at 8:00 p.m., to include the following; however, this staff person had no medication administration training:

Resident [REDACTED], and [REDACTED]

Resident [REDACTED] and [REDACTED]

**Plan of Correction**

Accept [REDACTED] - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.182(b), Administrator [REDACTED] immediately removed Staff Person D and Staff Person E from all medication administration duties pending successful completion of the required medication administration training as specified in § 2600.190. A review of the Medication Administration Records (MARs) for Residents [REDACTED] and [REDACTED] was conducted to verify accuracy of documentation and assess for any adverse outcomes related to the medications administered on the identified dates. The residents' prescribing practitioners were notified as appropriate, and no further medications were administered by untrained staff. This immediate corrective action to be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] ensured that Staff Person D and Staff Person E were enrolled in or successfully completed the Department approved medication administration training program prior to resuming any medication administration responsibilities. A comprehensive audit of all staff files was conducted to verify that any staff administering medications meet one of the qualifications outlined in § 2600.182(b)(1) (4). Any deficiencies identified were corrected immediately, and documentation of credentials and training completion was placed in each personnel file. All corrective measures to be completed on or before March 31, 2026.

**Preventative Action :**

Administrator [REDACTED] revised the facility's medication administration policy to require documented

**182b - Prescription Medication (continued)**

verification of appropriate licensure or successful completion of medication administration training prior to assignment of medication duties. A competency verification and training tracking process was implemented to ensure no staff person administers prescription medications unless fully qualified under § 2600.182(b). Ongoing supervisory audits of MARs and staff credentials will be conducted to ensure sustained compliance. These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( [REDACTED] - 04/20/2026)

**185a - Implement Storage Procedures****16. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], resident [REDACTED] was prescribed [REDACTED], blood glucose 3 times daily 70-140=0U, 141-180=2U, 181-220=4U, 221-260=6U, 261-300=8U, 301-340=10U, 341-400=12U, 401-500=14U, 501+ notify. On multiple dates and times resident, a blood glucose reading was taken; however, the blood glucose reading did not match the reading recorded on the resident's January 2026 Medication Administration Record (MAR):

| Date & Time | Glucometer | MAR        |
|-------------|------------|------------|
| [REDACTED]  | [REDACTED] | [REDACTED] |

**Plan of Correction**

Accept ( [REDACTED] - 03/10/2026)

**Immediate Action:**

Upon identification of discrepancies between Resident [REDACTED]'s glucometer readings and the January 2026 Medication Administration Record (MAR), Administrator [REDACTED] immediately initiated a review of the home's procedures related to the safe use and documentation of medications and medical equipment in accordance with § 2600.185(a). The glucometer memory was reviewed and reconciled with the MAR to verify accuracy of insulin dosing administered per sliding scale order. The prescribing practitioner was notified of the discrepancies as appropriate, and staff responsible for blood glucose monitoring and insulin administration were immediately re-instructed on proper use of the glucometer and accurate, real-time documentation procedures. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] conducted a comprehensive audit of medication administration practices, including blood glucose monitoring, insulin administration, and MAR documentation for all residents receiving diabetic management. The facility's written procedures for safe storage, access, security, distribution, and use of medications and medical equipment were reviewed and revised to clearly define steps for obtaining glucometer readings,

**185a Implement Storage Procedures (continued)**

documenting results accurately, and verifying insulin dosages prior to administration. All trained staff persons completed refresher training on these revised procedures, and competency evaluations were conducted. All corrective measures to be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] implemented ongoing monitoring processes, including monthly MAR audits and random glucometer memory checks, to ensure continued compliance with § 2600.185(a). A double verification process for insulin administration and documentation was established to reduce risk of transcription errors. Supervisory oversight was enhanced to ensure that only properly trained staff handle medications and medical equipment and that all procedures are consistently followed. These preventative measures to be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ([REDACTED] - 04/20/2026)

**187a - Medication Record****17. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], resident [REDACTED] was prescribed [REDACTED], take 1 tab by mouth once daily; however, the January 2026 Medication Administration Record (MAR) indicated [REDACTED], take 2 tab by mouth once daily.

On [REDACTED] resident [REDACTED] was prescribed multiple medications; however, the following medications did not include a purpose or diagnosis on the January 2026 MAR:

[REDACTED]

On [REDACTED], resident [REDACTED] was prescribed multiple medications; however, the following medications did not include a purpose or diagnosis on the January 2026 MAR:

[REDACTED]

On [REDACTED] resident [REDACTED] was prescribed multiple medications; however, the following medications did not include a purpose or diagnosis on the January 2026 MAR:

[REDACTED]

## 187a - Medication Record (continued)

## Plan of Correction

Accept ( ) - 03/10/2026)

## Immediate Action:

Upon identification of the violation of § 2600.187(a), Administrator [REDACTED] immediately conducted a reconciliation of Resident [REDACTED]'s physician orders and the January 2026 Medication Administration Record (MAR) to correct the Atorvastatin order to accurately reflect 20mg, take 1 tablet by mouth once daily, as prescribed. The MARs for Residents [REDACTED] and [REDACTED] were reviewed and updated to include the documented purpose or diagnosis for each prescribed medication, in accordance with regulatory requirements. Prescribing practitioners and/or pharmacy providers were consulted as necessary to verify accurate medication orders and corresponding indications. All corrections will be documented, and this immediate corrective action will be completed on or before March 8, 2026.

## Corrective Action:

Administrator [REDACTED] conducted a comprehensive audit of all resident MARs to ensure each medication record includes accurate transcription of physician orders, correct dosage and administration instructions, and the purpose or diagnosis for each medication as required by § 2600.187(a). Any discrepancies identified were promptly corrected and verified against current physician orders. Staff responsible for transcribing and maintaining MARs were retrained on proper documentation standards, including verification procedures when new orders are received. All corrective measures to be completed on or before March 31, 2026.

## Preventative Action:

Administrator [REDACTED] revised the facility's medication record policy to require a double-check system when transcribing physician orders to the MAR and to ensure inclusion of the medication's purpose or diagnosis at the time of entry. Monthly MAR audits were implemented to monitor ongoing compliance with § 2600.187(a). Ongoing supervisory oversight will ensure medication records remain complete, accurate, and consistent with current physician orders. These preventative measures to be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

## 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

On [REDACTED] resident [REDACTED] was prescribed [REDACTED] blood glucose 3 times daily 70-140=0U, 141-180=2U, 181-220=4U, 221-260=6U, 261-300=8U, 301-340=10U, 341-400=12U, 401-500=14U, 501+ notify. On the following dates at 5:00 p.m., glucometer readings were taken and insulin administered; however, the readings and units administered were not recorded on the resident's January 2026 Medication Administration Record (MAR):

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

1/13/26, 1/18/26, 1/21/26

## Plan of Correction

Accept ( ) - 03/10/2026)

## Immediate Action:

Upon identification of the violation of § 2600.187(b), Administrator [REDACTED] immediately conducted a review of Resident [REDACTED]'s glucometer memory and physician orders to reconcile blood glucose readings and insulin doses administered on 1/13/26, 1/18/26, and 1/21/26 at 5:00 p.m. The January 2026 MAR was updated to accurately reflect the readings obtained and the corresponding units of Insulin Aspart administered per sliding scale order. Staff responsible for the omissions were counseled and required to demonstrate competency in documenting blood glucose results and insulin administration at the time of administration. This immediate corrective action to be completed on or before March 8, 2026.

## Corrective Action:

Administrator [REDACTED] conducted a comprehensive audit of all MAR entries for residents receiving insulin or time-sensitive medications to ensure documentation is completed contemporaneously with administration as required by § 2600.187(b). All staff authorized to administer medications received retraining emphasizing the requirement that blood glucose readings and corresponding insulin doses must be recorded at the time the medication is administered. Competency evaluations were completed to ensure understanding and compliance. All corrective measures will be completed on or before March 31, 2026.

## Preventative Action:

Administrator [REDACTED] revised the medication administration policy to require real-time documentation of blood glucose readings and insulin administration, with supervisory spot-checks of MARs and glucometer memory to ensure accuracy and timeliness. A monitoring process was implemented to conduct monthly MAR audits and random documentation reviews to prevent recurrence. Ongoing oversight will ensure sustained compliance with § 2600.187(b). These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

## 187d - Follow Prescriber's Orders

## 19. Requirements

2600.

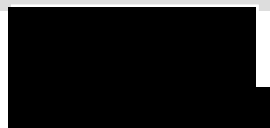
187.d. The home shall follow the directions of the prescriber.

## Description of Violation

On [REDACTED] resident [REDACTED] was prescribed [REDACTED], blood glucose 3 times daily 70-140=0U, 141-180=2U, 181-220=4U, 221-260=6U, 261-300=8U, 301-340=10U, 341-400=12U, 401-500=14U, 501+ notify. On multiple dates and times there were no glucose readings recorded on the glucometer or the January 2026 Medication Administration Record (MAR) and no insulin administered on the following:

Date &amp; Time

## 187d Follow Prescriber's Orders (continued)

**Plan of Correction**

Accept ( ) - 03/10/2026)

*Immediate Action:*

Upon identification of the violation of § 2600.187(d), Administrator [REDACTED] immediately reviewed Resident [REDACTED]'s physician orders for Insulin Aspart and verified the resident's current blood glucose management plan. Staff were instructed to ensure that all missed blood glucose checks and insulin administrations on 1/17/26 at 11:00 a.m. and 5:00 p.m., and 1/18/26 at 5:00 p.m., were promptly documented and any corrective actions for the resident's glycemic status were taken per prescriber guidance. Staff responsible for the omissions were counseled and required to follow prescriber orders exactly as written. This immediate corrective action will be completed on or before March 8, 2026.

*Corrective Action:*

Administrator [REDACTED] conducted a comprehensive audit of all insulin administration records and glucometer readings for residents receiving insulin to ensure adherence to prescriber directions in accordance with § 2600.187(d). Staff administering insulin received retraining on following prescriber orders precisely, completing all required blood glucose checks, and documenting insulin administration on the MAR at the time of administration. Competency evaluations were completed to ensure staff fully understand their responsibilities to follow prescriber directions. All corrective measures to be completed on or before March 31, 2026.

*Preventative Action:*

Administrator [REDACTED] implemented a monitoring system requiring supervisory staff to conduct verification of insulin administration and glucometer documentation to ensure compliance with prescriber orders. Written procedures were revised to reinforce timely blood glucose monitoring, accurate insulin administration, and documentation on the MAR. Ongoing monthly audits and random spot checks will be conducted to prevent recurrence and ensure continued compliance with § 2600.187(d). These preventative measures to be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

## 190b - Insulin Injections

**21. Requirements**

2600.

**190b Insulin Injections (continued)**

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

**Description of Violation**

On [REDACTED], the following staff persons did not successfully complete the Department approved diabetes patient education program within the last 12 months. However, these staff persons administered insulin to resident [REDACTED] prescribed [REDACTED] sub Q at bedtime, on the following dates and time:

| Staff person            | Date & Time             |
|-------------------------|-------------------------|
| Staff person [REDACTED] | [REDACTED] at 8:00 p.m. |
| Staff person [REDACTED] | [REDACTED] at 8:00 p.m. |
| Staff person [REDACTED] | [REDACTED] at 8:00 p.m. |

**Plan of Correction**

Accept [REDACTED] - 03/10/2026

**Immediate Action:**

Upon identification of the violation of § 2600.190(b), Administrator [REDACTED] immediately removed Staff Persons F, D, and E from all insulin administration duties. A review of Resident [REDACTED]'s Lantus Solostar administration on the identified dates and times was conducted to ensure resident safety and verify appropriate insulin dosing had occurred. Any concerns were communicated to the resident's prescribing practitioner, and documentation of the incident was completed. Staff were instructed that they may not administer insulin until successful completion of both the Department approved medication administration course and the Department approved diabetes patient education program. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] ensured that Staff Persons F, D, and E were enrolled in and successfully completed the Department approved diabetes patient education program, in addition to the Department approved medication administration course with the performance based competency test, as required under § 2600.190(b). Documentation of completion for both programs was placed in each staff member's personnel file. A review of all staff authorized to administer insulin was conducted to verify compliance with training requirements, and any deficiencies were corrected immediately. All corrective measures will be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] implemented a monitoring system requiring verification of completion of both the Department approved medication administration course and the Department approved diabetes patient education program for all staff prior to assignment of insulin administration duties. Ongoing supervisory audits of staff credentials and insulin administration logs were established to ensure continued compliance with § 2600.190(b). Staff education and reminders regarding mandatory training requirements for insulin administration were reinforced. These preventative measures to be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented [REDACTED] - 04/20/2026

**221c - Post Activity Calendar**

**22. Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

**Description of Violation**

On 1/22/26, the home did not have a weekly activity calendar posted in a public and conspicuous place in the home.

**Plan of Correction**

Accept ( ) - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.221(c), Administrator [REDACTED] immediately ensured that a current weekly activity calendar was created and posted in a conspicuous and public location accessible to all residents and staff. Staff were informed of the requirement to maintain visibility of the activity calendar at all times. This immediate corrective action will be completed on or before March 8, 2026.

**Corrective Action:**

Administrator [REDACTED] implemented a process to update and review the weekly activity calendar to ensure it accurately reflects scheduled resident activities. The calendar is now posted in a designated public area within the home, ensuring accessibility and visibility to residents, staff, and visitors. Staff were trained on the procedure for weekly updates and verification of posting to maintain compliance with § 2600.221(c). All corrective measures to be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] established a weekly verification process whereby designated staff confirm the current activity calendar is posted in the public area and matches scheduled activities. Any updates are documented and reviewed during weekly supervisory checks to ensure continued compliance with § 2600.221(c). Staff education on the importance of maintaining a visible, current activity calendar is reinforced during monthly staff meetings. These preventative measures will be fully implemented on or before March 31, 2026.

Licensee's Proposed Overall Completion Date: 03/31/2026

Not Implemented ( ) - 04/20/2026)

**225a Assessment 15 Days****23. 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**

On [REDACTED], Resident [REDACTED] admitted [REDACTED] did not have an assessment completed.

**Plan of Correction**

Accept ( ) - 03/10/2026)

**Immediate Action:**

Upon identification of the violation of § 2600.225(a), Administrator [REDACTED] immediately completed a written initial assessment for Resident [REDACTED] using the Department's required assessment form. The assessment included all required components to accurately reflect the resident's current physical, cognitive, and functional status. The completed assessment was placed in the resident's record, ensuring compliance with regulatory requirements. This immediate corrective action to be completed on or before March 8, 2026.

**225a - Assessment 15 Days (continued)****Corrective Action:**

Administrator [REDACTED] conducted a review of all residents admitted within the past 30 days to ensure each has a documented initial assessment completed on the Department's assessment form within 15 days of admission. Policies and procedures were revised to reinforce that the Administrator, designee, or authorized human service agency is responsible for completing and filing the assessment in a timely manner. Staff were trained on the requirement and proper documentation procedures. All corrective measures to be completed on or before March 31, 2026.

**Preventative Action:**

Administrator [REDACTED] implemented a tracking system to monitor completion of initial assessments for all new admissions, ensuring compliance within 15 days of admission as required by § 2600.225(a). Monthly audits of resident records will be conducted to verify timely assessment completion, and staff will be educated on adherence to this process. Ongoing supervisory oversight ensures that future admissions are assessed in accordance with regulatory requirements. These preventative measures will be fully implemented on or before March 31, 2026.

**Licensee's Proposed Overall Completion Date:** 03/31/2026

**Not Implemented ( [REDACTED] - 04/20/2026)**