pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GAHC3 YORK PA ALF TRS SUB LLC**
LEGAL ENTITY

To operate **SENIOR COMMONS AT POWDER MILL**
NAME OF FACILITY OR AGENCY

Located at **1775 POWDER MILL ROAD, YORK, PA 17403**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **166**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 44**

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

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

and shall remain in effect from **November 28, 2025** until **May 28, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **332102**

ISSUING OFFICER

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: MARCH 11, 2026

[redacted]
GAHC3 York PA ALF TRS SUB LLC
[redacted]

RE: Senior Commons at Powder Mill
1775 Powder Mill Road
York, Pennsylvania 17403
License/COC #: 332102

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on September 30, 2025, October 1, 2025, December 10, 2025 and December 11, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to <62 P.S. § 1026(b)(1) and 55 Pa. Code § 20.71(a)(2); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from November 28, 2025 to May 28, 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 SECOND 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 SECOND 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
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SENIOR COMMONS AT POWDER MILL* **License #**: *33210* **License Expiration**: *11/28/2025*

Address: *1775 POWDER MILL ROAD, YORK, PA 17403*

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *07/23/2001* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *169* **Waking Staff**: *127*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/01/2025*

Inspection Dates and Department Representative

09/30/2025 On Site: [redacted]

10/01/2025 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served**: *120*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Arlington and Rosewood* **Capacity**: *44* **Residents Served**: *33*

Hospice

Current Residents: *18*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *119*

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

Have Mobility Need: *49* **Have Physical Disability**: *0*

Inspections / Reviews

09/30/2025 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *11/02/2025*

11/03/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/03/2025*

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

11/12/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/03/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/03/2025*

02/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/03/2025*

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

18 Compliance With Laws

1. 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

Per 34 Pa.Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations (governed by Department of Labor and Industry), states "if a home has a boiler, it must have a valid Certificate of Boiler or Pressure Vessel Operation issued by the PA Department of Labor and Industry. Upon expiration of the certificate, boilers must be inspected, and if they pass inspection they will be issued a new certificate." The certificates for both of the boilers in the home had expired on [redacted] and [redacted] The boilers were not recertified until [redacted]

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: The annual inspection of both boilers took place on 1/3/25, as evidenced by the attached. During a QA review of the Inspection Binder on 8/11/25, it was noted a new certificate had not yet been received. On 9/27/25, Maintenance Director requested an updated certificate for the 1/3/25 annual inspection, which was received on 10/2/25.
Additional Corrective Actions: The Maintenance Director was educated by the Executive Director on 10/28/25 to review the Inspection Binder monthly to ensure that all necessary documents and certificates are updated and maintained, as well as understanding which certificates and documents must be updated and available for review in the Inspection Binder, to ensure all required maintenance and inspections is completed and documented. The monthly audits will begin 11/3/25.
Ongoing Quality Assurance Actions: Beginning 11/3/25, a monthly audit of the Inspection Binder will be completed by the Maintenance Director to ensure that we have a valid certificate of boiler pressure vessel operation issued by the PA Department of Labor and Industry. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/03/2025*

Implemented [redacted] - 02/17/2026)

23a Activities of Daily Living Assistance

2. Requirements

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

Description of Violation

Resident [redacted] current support plan, dated [redacted], included a requirement for [redacted] to have one-to-one staff supervision during waking hours. On [redacted] at 2:21pm, Resident [redacted] was awake and without one-to-one supervision in [redacted] bedroom. The assigned staff member was approximately 50 feet down the hall, sitting with their back to the resident's bedroom and conversing with other staff.

23a Activities of Daily Living Assistance (continued)

On [redacted] at 3:56 PM, Resident [redacted] assigned one to one staff member left the building. At 4:00 PM, Resident [redacted] was awake and unsupervised in [redacted] bedroom. Additional staffing did not arrive until 4:03 PM to provide one to one staffing to Resident [redacted]

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: On 10/1/25, Memory Care Director contacted Resident [redacted]s POA to discuss this matter, and the expectations of care provided by private duty aides. The private duty aides were counseled by Resident [redacted]s POA to ensure they remain engaged with the resident and provide supervision at all times during waking hours and do not leave prior to the end of their scheduled shift. In addition, the Memory Care Director educated all direct care staff in Memory Care on 10/2/25 to ensure they are aware of the need for supervision for Resident [redacted] and that supervision must be provided in the absence of a private duty caregiver any time the resident is awake. Resident [redacted] moved out of our facility 10/13/25.

Additional Corrective Actions: On 10/29/25, all direct care staff were trained by the Resident Care Director and Memory Care Director to ensure that they are aware of how to access RASPs, are able to identify care needs as documented in residents' support plans and understand how to meet those needs. In addition, all direct care staff were trained to understand that meeting care needs is the responsibility of the care team. Any time private duty or supplemental care providers are not available, direct care staff must ensure care needs are met, including when supervision must be provided.

Ongoing Quality Assurance Actions: Beginning on 11/3/25, changes in care needs will be addressed in monthly staff meetings by the Resident Care Director or Memory Care Director, and staff will be notified of all residents with private duty care, in addition to making notes of care need changes in the Communication Log. Monthly staff meetings, beginning on 11/3/25 will provide the opportunity for staff to confirm understanding and implementing RASPs, as well as to ask questions and network with other staff. Staff meetings will be conducted by the Resident Care Director or Memory Care Director, who will measure ongoing use of RASPs for addressing care needs. If at any time a resident does not have the supervision or care needed, direct care staff will provide it and notify their supervisor of the need to be addressed, effective 11/3/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Not Implemented [redacted] - 02/17/2026)

42e - Telephone Access

3. 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] Staff Member A reported the communal telephone located in the Secure Dementia Care Unit was unplugged from the wall and hidden in an upper kitchen cabinet due to a resident attempting to call 911 the day prior.

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: On 10/1/25, the Executive Director returned the phone to its original location. It is in working condition and is available for resident use.

Additional Corrective Actions: The Resident Care Director provided training on 10/29/25 to all direct care staff to ensure they understand residents have the right to access a phone in the home and have privacy for conversations.

42e - Telephone Access (continued)

Ongoing Quality Assurance Actions: The Memory Care Director will do a weekly audit beginning on 11/3/25 to ensure that a phone is accessible to the residents at all times. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/10/2025*

Implemented ([redacted] - 02/17/2026)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff Member B, hired on [redacted], does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: Staff Member B was removed from the schedule on 10/2/25, by Resident Care Director. Staff Member B will remain inactive and will not return to the schedule at any time.
Additional Corrective Actions: The Business Office Director was educated by Executive Director, on 10/28/25, to understand the qualification requirements and the need to verify them before offering employment. The Business Office Director will complete an audit to ensure that all current direct care staff persons have the following qualifications: high school diploma, GED, or active registry status on PA nurse aide registry by 11/26/25.
Ongoing Quality Assurance Actions: The Business Office Director will review a 5% sample of staff records each month to ensure all required documentation is in the record, beginning 11/14/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Not Implemented [redacted] 02/17/2026)

82a - Poisonous Materials

5. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On [redacted], two containers of cleaning wipes that did not include the manufacturer's label were located in Resident [redacted] bathroom.

Plan of Correction ***Accept ([redacted] - 11/03/2025)***

Immediate Corrective Actions: The poisonous material was removed from Resident [redacted]s room on 10/1/25, by Memory Care Director.

82a - Poisonous Materials (continued)

Additional Corrective Actions: On 10/29/25, the Resident Care Director trained all direct care staff on ensuring all poisonous materials are in original containers with labels and are stored appropriately. If any poisonous materials are found in alternative containers, with labels missing, or are not appropriately stored, staff will remove them and secure them in a locked area, and report the materials to their supervisor.
Ongoing Quality Assurance Actions: The Memory Care Director will do a daily walk through of the Memory Care Neighborhoods, beginning 11/1/25. In addition, the Maintenance Director will complete a daily walk through of the community, beginning 11/3/25. All department directors will complete a weekly check of a 5% sample of resident rooms beginning on 11/6/25. During the checks they will remove any poisonous materials that are not stored in their original containers or appropriately secured. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 02/17/2026)

82c - Locking Poisonous Materials

6. Requirements

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

Description of Violation

On [redacted] at 11:49 AM, there was a bottle of TopCare antiseptic mouthwash and Suave powder deodorant, both with a manufacturer's label indicating "to contact poison control center if ingested", were unlocked, unattended, and accessible in Resident [redacted] bathroom. Not all the residents of the home, including Resident [redacted] and Resident [redacted] have been assessed capable of recognizing and using poisons safely.

On [redacted] the following items with labels that indicate to "contact a poison control center if ingested" were unlocked, unattended and accessible in the Secure Dementia Care Unit shower room: Destin, gold bond lotion, gold bond powder, toothpaste, calmoseptine ointment, hand sanitizer, zeasorb AF miconazole nitrate 2% antifungal treatment, disinfectant spray, and act anticavity flouride mouthwash.

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: Poisonous materials were removed from the resident's room on 10/1/25, by Resident Care Director. Individual hygiene items were stored in labeled individual resident bins within the shower room, and the shower room was secured on 10/1/25, by Memory Care Director.
Additional Corrective Actions: On 10/29/25, the Resident Care Director educated caregivers and medication technicians that all poisonous materials must be stored safely and appropriately, to prevent access to them by individuals who are not capable of using them. This includes ensuring all storage areas are locked, residents are never left unattended in the shower room nor in the presence of poisonous materials, and that hygiene products are labeled and stored under the same guidelines. In addition, the door to the shower room will be updated to have an auto-close mechanism, with a keypad. This will be completed by the Maintenance Director, by 11/26/25.
Ongoing Quality Assurance Actions: The Memory Care Director will do a daily walk through of the Memory Care Neighborhoods, beginning 11/3/25. In addition, the Maintenance Director will complete a daily walk through of the community, beginning 11/3/25. This includes checking that common space storage areas are locked, including

82c - Locking Poisonous Materials (continued)

those in the shower room. All department directors will complete a weekly check of a 5% sample of resident rooms beginning on 11/3/25. During the checks they will remove any poisonous materials that are not stored in their original containers or appropriately secured. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 02/17/2026)

88a - Surfaces

7. 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 11:40 AM, an electrical outlet was protruding approximately 1/2" out of the floor in Rosewood Secure Dementia Care Unit. The outlet cover was directly in front of a chair utilized by residents in the living room area and creates a tripping hazard.

Plan of Correction ***Accept [redacted] 11/03/2025)***

Immediate Corrective Actions: The Maintenance Director screwed down the electrical outlet to make it flush with the floor on 10/2/25.
Additional Corrective Actions: On 10/28/25, the Executive Director provided training to Maintenance Director on the regulatory requirements of 88a- Floors, walls ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazard. In addition, an electrician will be contracted to remove floor outlets as needed. The Maintenance Director will coordinate this based on the electrician's availability and recommendations.
Ongoing Quality Assurance Actions: The Maintenance Director will complete a daily walk through of the community, starting 11/1/25. In addition, the Maintenance Director will complete a quarterly physical site inspection to ensure floors, walls, ceilings, windows, doors, and other surfaces are clean, in good repair, and free of hazards, as part of the QA Quarterly Review process, beginning with Q4 of 2025 (October, November, and December 2025). Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 02/17/2026)

91 - Telephone Numbers

8. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the main dining room, room [redacted], or room [redacted].

91 - Telephone Numbers *(continued)*

Plan of Correction ***Accept [redacted] - 11/03/2025)***

Immediate Corrective Actions: Emergency telephone numbers were posted by the Executive Director by the telephone in the main dining room, Room 812, and Room 115 on 10/1/25.
Additional Corrective Actions: On 10/29/25, the Resident Care Director educated caregivers and medication technicians on the importance and regulatory requirement for emergency telephone numbers to be posted at all phones so help can be quickly obtained in an emergency. In addition, the Maintenance Director completed an audit of all phones in the community to ensure they had emergency phone numbers posted. This will be completed by 11/25/25.
Ongoing Quality Assurance Actions: The Maintenance Director will check all common area phones and number postings during daily walk throughs, beginning 11/3/25. During weekly room audits all department directors will check to ensure that every phone has the emergency telephone numbers posted. This will begin 11/3/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/25/2025*

Implemented[redacted] - 02/17/2026)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

9. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There is no grab bar, handrail, or assist bar within reach of the toilets in rooms [redacted] and [redacted]

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate corrective actions: Grab bars were present in the bathrooms in rooms 108 and 406, across from the toilet, at the time of inspection. Additional grab bars were added in rooms 108 and 406 on 10/7/25 by the Maintenance Director. Due to the concern raised by Licensing Representatives about placement of the bars, residents in rooms 108 and 406 were assessed on 10/7/25 by the Resident Care Director to determine their ability to use the bars as intended.
Additional Corrective Actions: In addition, the Maintenance Director added additional grab bars on 10/7/25, in additional locations, noting the design of this room's floor plan creates limited bar placement opportunities without structural renovation. Staff will be educated by the Executive Director by 11/3/25 that all residents must be assessed through the RASP process to determine their ability to use the grab bars as needed, staff must provide care as noted in the RASP, and that changes in care needs will be reviewed and discussed at monthly staff meetings beginning 11/26/25 and in the Communication Log.
Ongoing Quality Assurance Actions: The Maintenance Director will audit 10% of resident rooms per to ensure that the toilet and bath area have grab bars, handrails, or assist bars, beginning 11/3/25. As part of ongoing care conferences and RASP updates, the Resident Care Director and Memory Care Director will ensure that residents who require the use of grab bars are able to use them in their bathrooms. When necessary, the care plan conference will include discussion of adaptive equipment options, such as raised toilet seats with side support rails. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)

Licensee's Proposed Overall Completion Date: *12/03/2025*

Not Implemented [redacted] - 02/17/2026)

141b1 - Annual Medical Evaluation

10. Requirements

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

Description of Violation

Resident [redacted] current annual medical evaluation, dated [redacted], does not include weight.

Resident [redacted] current annual medical evaluation, dated [redacted], does not include cognitive functioning.

Resident [redacted] current annual medical evaluation, dated [redacted] does not include weight.

Resident [redacted] current annual medical evaluation, dated [redacted], does not include height.

Resident [redacted] current annual medical evaluation, dated [redacted], does not include weight.

Plan of Correction ***Accept [redacted] - 11/03/2025)***

Immediate Corrective Actions: Resident [redacted] and [redacted]s documented medical evaluations were updated 10/2/25 by the Resident Care Director, Memory Care Director and Executive Director.
Additional Corrective Actions: The Executive Director provided training to the Resident Care Director and Memory Care Director on 10/28/25 to review all elements of the DME, so they can ensure they are fully completed before being submitted into the resident record. An audit of all residents most recent DMEs was completed on 10/6/25 by the Resident Care Director, Memory Care Director, and Executive Director to ensure all areas are complete.
Ongoing Quality Assurance Actions: Documented Medical Evaluations for all new move ins will be reviewed by Executive Director and Resident Care Director prior to being entered into our electronic medical records to ensure completion and accuracy, beginning on 11/1/25. A 5% sample of resident records will be reviewed each month by the Resident Care Director to ensure the DMEs are accurate and complete, beginning 11/1/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/01/2025*

Not Implemented [redacted] - 02/17/2026)

162c - Menus Posted

11. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] only the current week's menu from [redacted] was posted in the secure dementia care unit.

Plan of Correction ***Accept ([redacted] - 11/12/2025)***

Immediate Corrective Actions: The upcoming week's menu was posted in both of the secure dementia care neighborhoods on 10/1/25 by the Dining Services Director.
Additional Corrective Actions: The Executive Director trained the Dining Services Director and Memory Care Director on 162.c on 10/28/25 to ensure two weeks of menus are always posted.
Ongoing Quality Assurance Actions: The Dining Services Director hung frames for the menus on 10/2/25. The frames are labeled "This Week" and "Next Week". Each Friday, the Dining Services Director will provide the upcoming week's menu to the Memory Care Director, who will post the menu and ensure they are accurate, beginning 10/10/25. The Memory Care Director will complete a daily walk through of the memory care neighborhoods beginning on 11/3/25 to confirm the menus are posted. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented[redacted] - 02/17/2026)

183b - Meds and Syringes Locked

12. Requirements

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

Description of Violation

On [redacted] at 2:45 PM, [redacted] prescribed to Resident [redacted] was unlocked, unattended and accessible in the medicine cabinet of room [redacted] where resident [redacted] lives.

On [redacted] at 12:20 PM, [redacted] prescribed to Resident [redacted] was unlocked, unattended and accessible in Resident [redacted] bathroom.

On [redacted] at 2:29 PM, two bottles of [redacted] prescribed to Resident [redacted] were unlocked, unattended and accessible on a nightstand in Resident [redacted] room.

On [redacted] the following medications were unlocked, unattended and accessible in the secure dementia care unit shower room:

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

183b - Meds and Syringes Locked (continued)

Repeated Violation - [redacted] and [redacted] et al

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: On 9/30/25, Resident [redacted] was removed from [redacted] room by the Resident Care Director and stored appropriately and securely. On 9/30/25, Resident [redacted] was re-educated by the Resident Care Director that [redacted] must keep [redacted] door locked or utilize the locked box provided for [redacted] to ensure the appropriate storage of medications and safety of everyone in the community, per regulatory requirements and our policy. On 10/1/25, Resident [redacted] was removed from the room by the Resident Care Director and stored appropriately and securely. On 10/2/25, the items found in the Memory Care Shower Room were removed by Memory Care Director and Executive Director and stored appropriately and securely.
Additional Corrective Actions: On 10/29/25 Resident Care Director educated caregivers and medication technicians on the regulatory requirement and policy that all prescription medications, OTC medications, CAM, and syringes are to be kept in an area or container that is locked, including syringes. In addition, a letter was sent to residents and their responsible parties on 6/4/25 by Executive Director reminding them of the regulatory guidelines regarding medication storage. An additional letter will be sent to residents and their responsible parties by 11/26/25 by the Executive Director. This was also reviewed at June, July, August, September & October 2025 Town Hall meetings monthly, by Executive Director, and residents have been advised that noncompliance may result in receiving a 30-day notice to be discharged for failure to follow home rules and state regulations since May of 2025.
Ongoing Quality Assurance Actions: Beginning 11/3/25, all department directors will check a 5% sample of resident rooms weekly to ensure that if a resident has a medication in their room it is kept in an area or container that is locked. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented ([redacted] - 02/17/2026)

183e - Storing Medications

13. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] at 2:29 PM, two bottles of [redacted] were sitting on a nightstand in Resident [redacted]s room which are not labeled with the date of opening. According to the manufacturer's instructions, once the medication is opened, it can only be kept at room temperature for six weeks, and after six weeks must be thrown away.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: On 10/1/25 Latanoprost Ophthalmic Eye Solution was removed from the room by Resident Care Director.

183e - Storing Medications (continued)

Additional Corrective Actions: The Resident Care Director, Memory Care Director, and shift supervisors will review all new prescriptions to determine if there are any special storage guidelines or usage instructions to be met, beginning 11/3/25, and will ensure any necessary instructions are implemented and communicated in the Communication Log. All Medication Technicians will be trained to review the communication log for any storage/usage instructions regarding new medications by 11/26/25, by Resident Care Director.
Ongoing Quality Assurance Actions: Beginning on, 11/3/25 each week, all department directors will complete room checks to ensure that residents do not have medication in their room that they do not have a prescription for. A 5% audit of residents' rooms will be checked during all Director room checks, beginning 11/3/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Not Implemented ([redacted] - 02/17/2026)

184b - Labeling OTC/CAM

14. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted] treatment prescribed to Resident [redacted] was not labeled with the resident's name.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] 11/12/2025)***

Immediate Corrective Actions: On 9/30/25 [redacted] treatment was removed from the room, labeled correctly, and returned to the resident by the Resident Care Director.
Additional Corrective Actions: On 10/3/25, Resident [redacted] was educated by the Resident Care Director of the regulatory requirement and safety measure of ensuring the resident's name is noted on all medications the doctor determines may be safely stored in the resident's room. On 10/29/25, all staff were educated by Resident Care Director that all medications must have the resident's name on them, and any found without should be reported to their supervisor.
Ongoing Quality Assurance Actions: Beginning on 11/3/25 a 5% audit of resident rooms will be checked by all department directors to ensure that all medications which physicians have determined may be stored in resident rooms have the resident name on them, during weekly room audits. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 02/17/2026)

187d - Follow Prescriber's Orders

15. Requirements

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

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

Description of Violation

Resident [redacted] is prescribed [redacted] with orders to inject [redacted] subcutaneously twice daily at morning and bedtime for [redacted]. However, Resident [redacted] was administered 0 units on [redacted] in the morning and 0 units on [redacted] at bedtime.

Resident [redacted] is prescribed the following [redacted] sliding scale before meals and at bedtime: [redacted]. On [redacted] at 4:00 PM, Resident [redacted]s blood sugar was [redacted]. However, the resident was administered [redacted]. On [redacted] at 4:00 PM, Resident [redacted]s blood sugar was [redacted] However, the resident was administered [redacted] units.

Repeated Violation - [redacted] and [redacted] et al

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: Doctor and family notified by Resident Care Director 10/31/25. Resident had no side effects or medical concerns.
Additional Corrective Actions: Medication technicians were trained on reading glucometers and sliding scale insulin instructions on 10/31/25 by the Resident Care Director.
Ongoing Quality Assurance Actions: The Resident Care Director will check a 5% sample of sliding scale MARS each month beginning on 11/3/25 to confirm they are being administered per physician orders. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/03/2025*

Implemented [redacted] - 02/17/2026)

190a - Completion Medication Course

16. Requirements

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

Description of Violation

Staff Member C was certified to administer medications on [redacted] and not again until [redacted] Their recertification on [redacted] was outside the annual time frame requirement, and Staff Member C did not complete the required remediation including re-taking the entire medication administration course and initial requirements. Therefore, Staff Member C did not complete the Department's medication administration training requirements. Staff Member C administered the following medications to the following residents:

- *On [redacted] at 8:48 AM, [redacted] and [redacted] to Resident [redacted]*
- *On [redacted] at 9:08 AM, [redacted]*

190a - Completion Medication Course (continued)

- [redacted] to Resident [redacted]
- On [redacted] at 8:48 AM, [redacted], glucose checks at 12:00 PM and administration of 12:00 PM of [redacted] to Resident [redacted]

Plan of Correction ***Accept [redacted] - 11/12/2025)***

Immediate Corrective Actions: Staff member C was removed from the schedule on 10/5/25 and will not return to the cart unless or until all required training is completed and all required documentation is available for verification.
Additional Corrective Actions: By 11/26/25, the Medication Administration Train the Trainer will complete an audit of all Medication Technician records to ensure all required documentation is complete and up to date, to meet all regulatory requirements. The Business Office Director was educated by Executive Director, on 10/28/25 on the required documentation for all Medication Technicians and the BOD responsibility for verification of training and obtaining all necessary documentation to remain compliant with this regulation.
Ongoing Quality Assurance Actions: Beginning 11/3/25, the Resident Care Director will complete a monthly audit of Medication Training records for a 5% sample of all Medication Technicians, ensuring all medication technicians meet the training requirements. The Business Office Director will review a 5% sample of all staff records monthly and ensure that any Medication Technicians reviewed have the required documentation of training in their records. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/03/2025*

Implemented [redacted] - 02/17/2026)

231c - Preadmission Screening

17. Requirements

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

Description of Violation

Resident [redacted] preadmission screening, dated [redacted], did not include the resident's name or date of birth.

Plan of Correction ***Accept ([redacted] - 11/03/2025)***

Immediate Corrective Actions: On 10/1/25, Resident [redacted]s name and date of birth were added in the Pre-Admission Screening by Executive Director.
Additional Corrective Actions: The Executive Director provided training to the Resident Care Director and Memory Care Director on 10/28/25 to review all elements of the Pre-Admission Screening, so they can ensure they are fully completed before being submitted into the resident record. An audit of all residents' Pre-Admission Screenings will be completed by 11/28/25 by the Resident Care Director, Memory Care Director, and Executive Director to ensure all areas are complete.

231c - Preadmission Screening (continued)

Ongoing Quality Assurance Actions: Beginning on 11/1/25 Executive Director will review Pre-Admission Screenings prior to each admission to ensure they are accurate and thorough. The Resident Care Director will review a 5% sample of resident records each month, to confirm Pre-Admission Screenings are present and complete, beginning 11/1/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning with the 1/6/26 review of Q4 2025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] 02/17/2026)

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *SENIOR COMMONS AT POWDER MILL* **License #**: *33210* **License Expiration**: *11/28/2025*

Address: *1775 POWDER MILL ROAD, YORK, PA 17403*

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *07/23/2001* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *161* **Waking Staff**: *121*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date**: *01/12/2026*

Inspection Dates and Department Representative

12/10/2025 On Site: [redacted]
12/11/2025 On Site: [redacted]
12/12/2025 Off Site: [redacted]
01/02/2026 Off Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served**: *114*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Rosewood and Arlington Court* **Capacity**: *44* **Residents Served**: *33*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *114*

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

Have Mobility Need: *47* **Have Physical Disability**: *0*

Inspections / Reviews

12/10/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/14/2026*

02/18/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/18/2026*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

02/18/2026 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *02/18/2026*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] at 9:46 AM, the Tabula-Pro Medication Administration Record (MAR) for Resident [redacted] was unlocked, unattended, and accessible on the laptop located on top of the medication cart for hall [redacted] The information accessible included Resident [redacted] room number, date of birth and medications for morning administration including [redacted], and [redacted] along with the diagnosis of what the medications were prescribed for, the schedule of administration, route and dosage.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions: On 12/10/2025, at the time of the inspection, the Resident Care Director went to each medication cart to ensure that all resident records were secure, by locking the screens of any laptops that were not actively being used. Locked screens can only be unlocked by entering a password.
Additional Corrective Actions: On 12/10/2025, the Resident Care Director met with the Medication Technician responsible for the laptop that had been accessible and educated them on the regulation regarding confidentiality and the need to lock the screen of the laptop when not in use to keep residents' information private. The Resident Care Director will review with all Medication Technicians the regulation regarding confidentiality and the need to lock the screen of the laptop when not in use to keep residents' information private at a staff meeting scheduled for 2/25/26.
Ongoing Quality Assurance Actions: Starting 2/20/26, the Resident Care Director will do a daily walkthrough at varying times, checking every medication cart to ensure laptop screens are locked when not in use. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

Proposed Overall Completion Date: 04/25/2026

Licensee's Proposed Overall Completion Date: *04/25/2026*

42b Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident [redacted] current assessment and support plan (RASP), dated [redacted], indicates when the resident is unable to find [redacted] spouse, the resident becomes physical aggressive hitting [redacted] on the head, choking [redacted] becomes verbally aggressive towards staff and becomes aggressive towards other residents in the home. Resident [redacted]s RASP also indicates that as a result of these behaviors, the resident has a private duty aide during waking hours to redirect the resident.

42b - Abuse (continued)

On [redacted] at 6:58 PM, Resident [redacted] was in [redacted] room when Staff Member A, the resident's private duty aide, went into the resident's bathroom. Almost immediately, Staff Member A heard screaming in the hallway. When Staff Member A went into the hallway, Resident [redacted] was using [redacted] right arm to pin Resident [redacted] shoulder to the wall. Resident [redacted] was yelling for help and sliding down the wall. Resident [redacted] was "clawing" at Resident [redacted] with [redacted] nails in an effort to try to get free. Staff Member A yelled for assistance then restrained Resident [redacted] by holding the resident's hands behind [redacted] back. Resident [redacted] remained on the floor and screaming until emergency medical services arrived to take [redacted] to the hospital. Residents [redacted] and [redacted] were both transported to the hospital. During an interview Staff Member A, that stated when Resident [redacted] returned from the hospital, [redacted] had scratch marks all over [redacted] face. Staff Member A reported they have had to restrain Resident [redacted] on multiple occasions prior to this incident due to Resident [redacted]s aggressive behaviors.

On [redacted] at approximately 6:45 PM, a resident's family member informed Staff Member F, the Memory Care Director, that Resident [redacted] was touching Resident [redacted]s penis with [redacted] hand in the dining room of the Secured Dementia Care Unit (SDCU). Residents [redacted] and [redacted] did not recall the incident when asked by Staff Member F and Staff Member G later that evening. According to Resident [redacted]s current assessment and support plan, dated [redacted], indicates Resident [redacted] has a diagnosis of [redacted] with impaired judgement. During an interview with Resident [redacted] on [redacted], the resident could not recall any details of [redacted], and Resident [redacted] declined to be interviewed. There is no indication in either Resident [redacted] or Resident [redacted]s records indicating their ability to consent to sexual contact, and the home has not had either resident evaluated by a medical professional to determine the residents' ability to consent.

Plan of Correction ***Directed [redacted] - 02/18/2026)***

Immediate Corrective Actions: Resident [redacted] and Resident [redacted] were immediately redirected to separate areas and sent to York Hospital for further evaluation. Resident [redacted] and Resident [redacted] were also immediately redirected to separate areas and assessed, with neither resident found to have injuries nor be in distress. In both cases, all necessary reports were made to physicians and responsible parties, as well as Aging and DHS.

Additional Corrective Actions: On 2/25/26, the Memory Care Director and the Resident Care Director held a training with Direct Care Staff and Medication Technicians to review Resident Rights, using structured activities and our Typical Day programming to keep residents engaged, being observant for signs of increased anxiety in residents with dementia, and navigating challenging situations with residents while maintaining dignity and respect. On 12/24/25, Memory Care Director updated the resident's records for all of these residents to reflect these incidents and interactions, as well as the support in place for each of them.

In addition, the community will update its policies to include that, following an initial interaction of abusive behavior with another person, the resident will be required to have one-to-one private duty care as part of the updated RASP to ensure the safety and well-being of all residents. In the event of a second incident, a 30-day notice of discharge will be issued as a different or higher level of care will be necessary if one-to-one care is not adequate to keep residents safe. As always, any time a 30-day notice is issued, the community will provide assistance in finding alternative residence in accordance with regulatory guidelines and community procedures. The policy will be updated by 2/27/26, at which time a 30-day notice of the policy will be provided to all residents, for the policy to become effective on 4/1/26.

Ongoing Corrective Actions: Resident [redacted] moved out of Senior Commons at Powder Mill on 11/17/25. Resident [redacted] had no injuries and no changes to care needs. Resident [redacted] returned to us from the hospital on 12/23/25 and moved to a new room at Senior Commons, after care planning discussions with the resident's designee, to provide a different environment for Resident [redacted] Resident [redacted] also had private duty put in place upon their return to Senior

42b - Abuse (continued)

Commons from the hospital to provide more 1:1 engagement. Resident [redacted]s RASP was updated 12/24/25 and there have been no further concerns. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

[Directed]

- *In addition to the above steps, beginning 2/20/26, the Executive Director, the Resident Care Director, and the Memory Care Director will review changes in resident care needs and behavioral issues in the Daily Huddle, so they are able to outline supports needed in the RASP.*

Proposed Overall Completion Date: 04/25/2026

Directed Completion Date: *04/25/2026*

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

3. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There was no grab bar, handrail or assist bar in a reachable distance in Resident [redacted]s bathroom. Resident [redacted]s current medical evaluation, dated[redacted], indicates the resident requires moderate assistance for mobility. Resident [redacted]s current assessment and support plan, dated[redacted], indicates Resident [redacted] is unsteady at times and cannot pull clothes up or down during bathroom use.

There was no grab bar, handrail or assist bar in a reachable distance in Resident [redacted]s bathroom. Resident [redacted]s current medical evaluation, dated[redacted], indicates the resident utilizes a walker to ambulate and is assessed as having moderate immobility.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions: On 12/11/25, the Maintenance Director added reachable bars in Resident [redacted] and Resident [redacted]s bathrooms, by installing "over the toilet safety bars", which provide side rails in a position to similar to arm rests, in addition to the grab bars located on the wall in front of the toilet.
Additional Corrective Actions: The Executive Director will train all Department Directors on the requirements regarding grab bars/handrails/and assist bars in bathrooms by 2/20/26. The Executive Director, the Resident Care Director, and the Memory Care Director, in collaboration with Fox Therapy Services will assess all current residents regarding their ability to use the bathroom, the existing grab bar, and the assistance they need to safely use the bathroom by 3/16/26 and ensure their RASPs are updated and accurate by 4/1/26. The Maintenance Director will purchase 10 "over the toilet safety bars" by 4/1/26 and will install those in the bathrooms for residents who use the bathroom without staff assistance and require the use of a grab bar and are not able to use the grab bar currently in their bathroom. If additional over the toilet safety bars are needed, they will be purchased, and a supply of 5 will be maintained for additional needs as they arise or change. The chosen safety bars incur a cost of approximately $80 per item, because they are of high quality and are able to support up to 350 pounds. Because of this significant cost, additional safety bars will be bought on an as-needed basis, while maintaining a supply of 5. Beginning 3/1/26, as

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)

new residents are scheduled to be admitted, they will be assessed by the Executive Director, the Resident Care Director, the Memory Care Director, and/or FOX Therapy Services to determine if an over-the-toilet safety bar is needed in addition to the grab bar in front of the toilet. When needed, they will be installed no later than the day of admission.

Ongoing Quality Assurance Actions: This community has been providing personal care services for over 40 years, has been licensed by DHS since the inception of the 2600 regulations, and had not been cited for this prior to the most recent annual inspection. Due to the structure of the bathrooms, with a sink on one side of the toilet and a shower on the other, there is no physical space to attach a grab bar to the side of the toilet, thus the placement of the grab bar on the wall in front of the toilet. That cannot be changed without structural changes to approximately 100 bathrooms, creating a prohibitive financial cost that is not feasible. Starting 3/1/26 the Department Directors will each audit a portion of the residents' rooms weekly, to ensure all are inspected each week. The inspection will include checks for grab bars in all bathrooms. Beginning 3/1/26, the Executive Director, the Resident Care Director, and the Memory Care Director will discuss during Daily Huddles any changes in care needs that arise for residents. It will be reported to the Maintenance Director if any bathrooms do not have a grab bar so that one can be added, or if an additional over the toilet seat safety bar is needed. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

Proposed Overall Completion Date: 04/25/2026

Licensee's Proposed Overall Completion Date: *04/25/2026*

142a - Secure Medical Care

4. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. Resident's initial medical evaluation, dated [redacted] indicated Resident [redacted]s weight was [redacted] and Resident [redacted]s hospital discharge summary, dated [redacted], indicated Resident [redacted]s weight was [redacted], totally a [redacted]. During interviews with Staff Member F, the Memory Care Director, and Staff Member K, the Resident Care Director, it was reported Resident [redacted] had a declining appetite, frequently declined meals and took a long time to initiate eating meals. Resident [redacted]s weight and declining appetite were not being monitored, and there was no follow-up with Resident [redacted]s physician regarding [redacted] lack of appetite or subsequent weight loss.

Plan of Correction ***Accept [redacted] 02/18/2026)***

Immediate Corrective Actions: By 3/2/26, the Executive Director will train the Memory Care Director and the Resident Care Director on the expectation to assist residents with securing medical care as needed per the resident RASP; reporting to physicians changes in health and overall well-being; reviewing changes and documentation to determine when there are patterns, trends, and when events such as changes in ADLs or IADLs should be reported to physicians and responsible parties.

Additional Corrective Actions: On 2/25/26, the Resident Care Director and the Memory Care Director will train Direct Care Staff and Medication Technicians to report changes in condition, mental status, personality, and functioning to Management immediately, as well as the need to document such changes. Beginning 2/20/26, Direct Care Staff

142a Secure Medical Care (continued)

and Medication Technicians will complete Shift Change Responsibility Forms at the change of every shift, which includes reviewing changes and updates related to resident care needs and support plan.
Ongoing Quality Assurance Actions: Beginning 2/20/26, the Executive Director, the Resident Care Director, and the Memory Care Director will review changes in resident care needs in the Daily Huddle, so they document and follow up with physicians and families as needed. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

Proposed Overall Completion Date: 04/25/2026

Licensee's Proposed Overall Completion Date: *04/25/2026*

190c - Record of Training

5. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff Member H does not include Medication Trainer Attestation for Staff Member H's initial medication administration training completed on [redacted]

The home's medication administration training record for Staff Member I does not include the Medication Trainer Attestation for Staff Member I's initial medication administration training, completed on [redacted].

Plan of Correction ***Directed*** [redacted] ***- 02/17/2026)***

Immediate Corrective Actions: By 3/2/26, the Executive Director will train the Memory Care Director and the Resident Care Director on the expectation to assist residents with securing medical care as needed per the resident RASP; reporting to physicians changes in health and overall well being; reviewing changes and documentation to determine when there are patterns, trends, and when events such as changes in ADLs or IADLs should be reported to physicians and responsible parties.
Additional Corrective Actions: On 2/25/26, the Resident Care Director and the Memory Care Director will train Direct Care Staff and Medication Technicians to report changes in condition, mental status, personality, and functioning to Management immediately, as well as the need to document such changes. Beginning 2/20/26, Direct Care Staff and Medication Technicians will complete Shift Change Responsibility Forms at the change of every shift, which includes reviewing changes and updates related to resident care needs and support plan.
Ongoing Quality Assurance Actions: Beginning 2/20/26, the Executive Director, the Resident Care Director, and the Memory Care Director will review changes in resident care needs in the Daily Huddle, so they document and follow up with physicians and families as needed. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

[Directed]
The home's medication administration trainer will complete the Medication Trainer Attestation for Staff Member H and Staff Member I by 3/16/26.
The administrator or designee will educate staff responsible for completing staff medication administration training and maintaining staff medication administration training records on regulation 2600.190(c). This education will be

190c Record of Training (continued)

completed by 3/16/26. Documentation of this education will be kept and available for review by the Department.

The administrator or designee will complete an initial audit of all current medication technician training records to ensure all parts of these trainings are completed. This will be completed by 3/16/26. Documentation of this audit will be kept and available for review by the Department.

Beginning no later than 3/16/26, the administrator or designee will complete quarterly audits of medication technician training records for completeness. Documentation of these audits will be kept and available for review the Department.

Directed Completion Date: *04/25/2026*

202 - Prohibitions

6. Requirements

2600.
202. The following procedures are prohibited:
6. A manual restraint, define[illegible]as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move [illegible] arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompti[illegible] escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [illegible] at 6:58 PM, Resident [illegible] was in [illegible] room when Staff Member A, the resident's private duty aide, went into the resident's bathroom. Almost immediately, Staff Member A heard screaming in the hallway. When Staff Member A went into the hallway, Resident [illegible] was using [illegible] right arm to pin Resident [illegible]s shoulder to the wall. Resident [illegible] was yelling for help and sliding down the wall. Resident [illegible] was "clawing" at Resident [illegible] with [illegible] nails in an effort to try to get free. Staff Member A yelled for assistance then restrained Resident [illegible] by holding the resident's hands behind [illegible] back. Resident [illegible] remained on the floor and screaming until emergency medical services arrived to take [illegible] to the hospital. Residents [illegible] and [illegible] were both transported to the hospital. During an interview Staff Member A, that stated when Resident [illegible] returned from the hospital, [illegible] had scratch marks all over [illegible] face. Staff Member A reported they have had to restrain Resident [illegible] on multiple occasions prior to this incident due to Resident [illegible]s aggressive behaviors.

Plan of Correction ***Accept [illegible] - 02/17/2026)***

Immediate Corrective Actions: Staff Member A is not a staff member at Senior Commons at Powder Mill. They were a private duty caregiver hired by Resident [illegible]s family. Following the incident, an investigation was completed, and the private duty caregiver did not disclose any use of restraints. Resident [illegible] moved out of our memory care neighborhood on 11/17/25. Staff member A has not returned to the building since 11/17/25. Upon receipt of the LIS, and learning of the alleged repeated use of restraints, Staff Member A has been banned from returning to the community.

Additional Corrective Actions: On 2/25/26, the Memory Care Director and the Resident Care Director will hold a training with Direct Care Staff and Medication Technicians to review Resident Rights, using structured activities and our Typical Day programming to keep residents engaged, being observant for signs of increased anxiety in residents, and navigating challenging situations with residents while maintaining dignity and respect, in addition to a review of the definitions of prohibited restraints as noted in Regulation 2600.202, and the use of Safe Management Techniques to de escalate situations. By 2/20/26, the Resident Care Director and the Memory Care Director will train Direct Care Staff and Medication Technicians to report changes in condition, mental status, personality, and behaviors to Management immediately, as well as the need to document such changes on the Shift Change Responsibility Forms at the change of every shift.

202 - Prohibitions (continued)

In addition, the Private Duty Addendum will be updated to include that all Private Duty Caregivers are required to report to community staff all matters of abuse or neglect as outlined in OAPSA, which will be reported per regulatory requirement; and are also required to report to community staff all changes in resident care needs, which will be updated in the resident RASP accordingly. The Private Duty Addendum will further outline the right of the community to rescind contracts or ban private duty caregivers who do not follow regulatory requirements and/or community policies and procedures. The Private Duty Addendum will be updated by 2/27/26, with a 30 Day Notice being provided to all residents, so that it will become effective 4/1/26.
Ongoing Corrective Actions: Beginning 2/20/26, the Executive Director, the Resident Care Director, and the Memory Care Director will review changes in resident care needs and behavioral issues in the Daily Huddle, so they are able to outline supports needed in the RASP. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

Proposed Overall Completion Date: 04/25/2026

Licensee's Proposed Overall Completion Date: *04/25/2026*

234d - Support Plan Revision

7. Requirements

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

Description of Violation

Resident [redacted]s current support plan, dated [redacted] does not include the incident of sexual contact Resident [redacted] had with another resident on [redacted]

Resident [redacted]s current support plan, dated [redacted], was not updated to include an unwitnessed fall Resident [redacted] had on [redacted] at 8:29 AM. The resident was sent to the hospital as a result of the unwitnessed fall. The discharge summary from this hospital visit indicated a primary diagnosis of [redacted], which also was not updated on the resident's assessment and support plan. On [redacted], Resident [redacted] experienced a second unwitnessed fall, and was transported to the hospital. On [redacted] the resident was discharged from the hospital to another personal care home. The resident was placed on hospice services and died on Resident [redacted]s date of death. The resident's death certificate indicated the cause of death was a [redacted] due to the [redacted]

Resident [redacted] also had a declining appetite, frequently declined meals and took a long time to initiate eating meals per staff interviews with Staff Member F, the Memory Care Director, and Staff Member K, the Resident Care Director. The resident had lost a total of 16 pounds from [redacted] to [redacted]. However, this information was also not included in the resident's current support plan.

Plan of Correction ***Accept [redacted] - 02/17/2026)***

Immediate Corrective Actions: A new RASP was completed for Resident [redacted] for significant change on 12/23/25, by the Memory Care Director. An Update and Change was added to Resident [redacted]s RASP on 12/24/25, noting [redacted] interaction with another resident, by the Memory Care Director. Resident [redacted] RASP was not updated because [redacted] did not return to us.
Additional Corrective Actions: On 2/25/26, the Resident Care Director and the Memory Care Director will train Direct Care Staff and Medication Technicians to report changes in condition, mental status, personality, and functioning to Management immediately, as well as the need to document such changes. Beginning 2/20/26, Direct Care Staff

234d - Support Plan Revision (continued)

and Medication Technicians will complete Shift Change Responsibility Forms at the change of every shift, which includes reviewing changes and updates related to resident care needs and support plan.
Ongoing Quality Assurance Actions: Beginning 2/20/26, the Executive Director, the Resident Care Director, and the Memory Care Director will review changes in resident care needs in the Daily Huddle, so they document them in RASP Updates and Changes as needed. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 04/09/2026.

Proposed Overall Completion Date: 04/25/2026

Licensee's Proposed Overall Completion Date: *04/25/2026*