



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to MANATAWNY AL OPERATING COMPANY LLC

LEGAL ENTITY

To operate THE RESIDENCES AT MANATAWNY VILLAGE

NAME OF FACILITY OR AGENCY

Located at 30 OLD SCHUYKILL ROAD, POTTSTOWN, PA 19465

(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 124
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 24

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 December 6, 2025 until December 6, 2026,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **148510**


ISSUING OFFICER


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 628 - 04/23



Pennsylvania Department of Human Services

[REDACTED]
Sole Member
Manatawny AL Operating Company, LLC
[REDACTED]
[REDACTED]

RE: The Residences at Manatawny Village
30 Old Schuylkill Road
Pottstown, Pennsylvania 19465
License #: 14851

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on October 6 and 7, 2025 and January 12 and 13, 2026, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

April 1, 2026

[REDACTED]
MANATAWNY AL OPERATING COMPANY LLC
[REDACTED]
[REDACTED]

RE: THE RESIDENCES AT MANATAWNY
VILLAGE
30 OLD SCHUYKILL ROAD
POTTSTOWN, PA, 19465
LICENSE/COC#: 14851

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/06/2025, 10/07/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE RESIDENCES AT MANATAWNY VILLAGE

License #: 14851

License Expiration: 12/06/2025

Address: 30 OLD SCHUYKILL ROAD, POTTSTOWN, PA 19465

County: CHESTER

Region: SOUTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: MANATAWNY AL OPERATING COMPANY LLC

Address:

Phone:

Email:

Certificate(s) of Occupancy

Type: C 1

Date: 08/15/1989

Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 72

Waking Staff: 54

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Provisional

Exit Conference Date: 10/07/2025

Inspection Dates and Department Representative

10/06/2025 On Site:

10/07/2025 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 124

Residents Served: 53

Secured Dementia Care Unit

In Home: Yes

Area: Horizons

Capacity: 24

Residents Served: 19

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 53

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 19

Have Physical Disability: 0

Inspections / Reviews

10/06/2025 - Full

Lead Inspector:

Follow Up Type: POC Submission

Follow Up Date: 11/09/2025

Inspections / Reviews (*continued*)

11/17/2025 POC Submission

Submitted By: *Joanna Kehoe*Date Submitted: *12/19/2025*Reviewer: *Michele Swisher*Follow Up Type: *POC Submission*Follow Up Date: *11/20/2025*

12/04/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: *12/19/2025*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission* Follow Up Date: *12/19/2025*

04/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: *12/19/2025*

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

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 9:41 AM, resident records and medications were unlocked, unattended, and accessible in the medication room located behind the nursing station. The door was propped open with a trash can and there was no staff in the area.

At 9:57 AM the medication cart was found unlocked, unattended and accessible, with a narcotic administration logbook set on top and a computer screen open with resident medication information easily visible to anyone that passes by.

Repeat Violation Date [REDACTED] et al.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* All resident records and medications were immediately secured upon exit conference. Staff were re-educated on confidentiality policies.
- *Systemic Change:* Signage placed on medication room door to remain closed at all times. Extra key for second nurses obtained and made available. A strict "no unattended medication cart" policy implemented. Disciplinary action for non-compliance.
- *Person Responsible:* Director of Nursing (DON)
- *Completion Date:* Re-education completed 10/08/2025.

Licensee's Proposed Overall Completion Date: 11/30/2025

Update: 11/17/2025

Please indicate the specific date for staff re-education.

Please indicate a specific step or action to monitor or audit for on-going compliance, such as, daily spot checks to ensure areas are secure, weekly random audits etc. Please include specific start dates, frequencies, and title of person responsible.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* All resident records and medications were immediately secured upon exit conference. Staff were re-educated on confidentiality policies.
- *Systemic Change:* Signage placed on medication room door to remain closed at all times. Extra key for second nurses obtained and made available. A strict "no unattended medication cart" policy implemented. Disciplinary action for non-compliance.
- *Person Responsible:* Director of Nursing (DON)
- *Completion Date:* Re-education completed 10/08/2025.

- Staff was reeducated on 11/14/2025

- The DON and the PCHA will conduct weekly spot checks that will start on 11/24/2025

17 - Record Confidentiality (continued)

Licensee's Proposed Overall Completion Date: 11/24/2025

Evidence of Completion

Implemented () - 03/30/2026)

See attached.

25b - Contract Signatures

2. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated (), for resident () was not signed by the resident.

Plan of Correction

Do Not Accept () - 11/17/2025)

- *Corrective Action: Resident 1's contract, dated 10/2/2025, was signed by residents POA on 10/1/2025, copy obtained and placed in residents financial folder.*
- *Systemic Change: An "Admission Packet Checklist" implemented. The Business Manager must verify all contracts are fully executed within 24 hours of admission.*
- *Person Responsible: Business Manager*
- *Completion Date: Corrected 10/08/2025; Checklist implemented 10/15/2025.*

Licensee's Proposed Overall Completion Date: 11/30/2025

Update: 11/17/2025

Please indicate a date that the resident was offered a chance to review and sign the contract.

Please indicate any additional in-service provided to all persons responsible for ensuring compliance with this regulation.

Please indicate method to audit for ongoing compliance as well as an initial audits to ensure all files are currently compliant. Include specific dates, frequency and titles of persons responsible.

Plan of Correction

Accept () - 12/04/2025)

- *Corrective Action: Resident () contract, dated 10/2/2025, was signed by residents POA on 10/1/2025, copy obtained and placed in residents financial folder.*
- *Systemic Change: An "Admission Packet Checklist" implemented. The Business Manager must verify all contracts are fully executed within 24 hours of admission.*
- *Person Responsible: Business Manager*
- *Completion Date: Corrected 10/08/2025; Checklist implemented 10/15/2025.*

- contract was signed and reviewed on 10/08/2025

- A check list/audit was created for the business manager to audit and verify compliance

- An admissions check list packet will serve as the audit tool for the business office manager

- Audit to be completed before moving in and annually

25b - Contract Signatures (*continued*)

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented () - 03/30/2026)

See attached.

26a - Quality Management Plan

3. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home does not have a quality management plan.

Plan of Correction

Do Not Accept () - 11/17/2025)

- *Corrective Action: A comprehensive Quality Management Plan (QMP) has been developed and implemented.*
- *Systemic Change: A QMP Committee, led by the Administrator, will meet bi-weekly to conduct and review audits on medication, training, and environment.*
- *Person Responsible: Administrator*
- *Completion Date: QMP implemented 11/05/2025.*

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

Update: 11/17/2025

Please clarify what bi-weekly means- every two weeks or twice a week.

Please indicate the start date for the bi-weekly meetings.

Plan of Correction

Accept () 12/04/2025)

- *Corrective Action: A comprehensive Quality Management Plan (QMP) has been developed and implemented.*
- *Systemic Change: A QMP Committee, led by the Administrator, will meet bi-weekly to conduct and review audits on medication, training, and environment.*
- *Person Responsible: Administrator*
- *Completion Date: QMP implemented 11/05/2025.*

- Meeting will hold place every other Wednesday, they started on 11/12/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented () - 03/30/2026)

See attached.

28e - Death of a Resident

4. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

28e - Death of a Resident (*continued*)**Description of Violation**

Resident [REDACTED] passed away on [REDACTED]. Resident [REDACTED] personal belongings were removed on from the [REDACTED] room on [REDACTED]; however, resident [REDACTED]'s estate is owed a refund of [REDACTED] which has not yet been issued.

Plan of Correction

Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* A refund check for [REDACTED] will be issued to the estate of Resident [REDACTED]
- *Systemic Change:* The Business Office will run a weekly report of PC discharges to trigger automatic financial reviews for refunds within the 30-day window.
- *Person Responsible:* Business Manager
- *Completion Date:* Refund will be issued by 11/7/2025; Procedure implemented 11/5/2025

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

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

41e - Signed Statement

5. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident [REDACTED]'s record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* Facility located copy of Resident [REDACTED] signed acknowledgment of resident rights and complaint procedures.
- *Systemic Change:* The "Admission Packet Checklist" includes verification of this signed statement prior to or upon admission.
- *Person Responsible:* Social Service Designee
- *Completion Date:* Corrected 10/10/2025.

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

Update: 11/17/2025

Please indicate method to audit for ongoing compliance as well as an initial audits to ensure all files are currently compliant. Include specific dates, frequency and titles of persons responsible

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* Facility located copy of Resident [REDACTED] signed acknowledgment of resident rights and complaint procedures.
- *Systemic Change:* The "Admission Packet Checklist" includes verification of this signed statement prior to or upon admission.
- *Person Responsible:* Social Service Designee
- *Completion Date:* Corrected 10/10/2025.

41e - Signed Statement (continued)

- An admission packet will include a check list which will serve as the audit to ensure compliance
- Audit will be completed prior to admission
- The social service director will complete the audit prior to a move in

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

51 - Criminal Background Check**6. 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's was first hired [REDACTED], a background check was not completed until [REDACTED]

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- **Corrective Action:** The hiring file for Staff Person A has been reviewed. All current staff files audited to ensure background checks are completed pre-hire.
- **Systemic Change:** The HR Coordinator must verify the completion and clearance of all required background checks before any new employee's first day of work.
- **Person Responsible:** Administrator / HR Coordinator/Staffing Coordinator
- **Completion Date:** Audit completed 10/25/2025; Policy reinforced 10/08/2025.

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. please indicate the specific method to audit or monitor for ongoing compliance with new employees.

Plan of Correction

Accept [REDACTED] 12/04/2025)

- **Corrective Action:** The hiring file for Staff Person A has been reviewed. All current staff files audited to ensure background checks are completed pre-hire.
- **Systemic Change:** The HR Coordinator must verify the completion and clearance of all required background checks before any new employee's first day of work.
- **Person Responsible:** Administrator / HR Coordinator/Staffing Coordinator
- **Completion Date:** Audit completed 10/25/2025; Policy reinforced 10/08/2025.

- HR will be provided the appropriate education to keep up with compliance on background checks
- Background checks will be completed before the staff their first day of work, HR will complete an audit each time a new employee gets onboarded.

51 - Criminal Background Check (continued)

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

62 - Contact List**7. Requirements**

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person B, the administrator, maintains a list of staff persons that does not include all staff persons of the building who perform duties in personal care, and the contact information of substitute staff.

Repeat violation: [REDACTED] et al

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* The staff contact list has been updated to include all personal care staff and substitute personnel with current contact information.
- *Systemic Change:* The Administrator will update the list bi-weekly and upon any staffing change. A master list is kept at the main nursing station and with the Administrator.
- *Person Responsible:* Administrator
- *Completion Date:* List updated 10/08/2025.

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

Update: 11/17/2025

Please clarify if bi-weekly means every two weeks or twice weekly.

Please indicate the start date for the bi-weekly updates.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* The staff contact list has been updated to include all personal care staff and substitute personnel with current contact information.
- *Systemic Change:* The Administrator will update the list bi-weekly and upon any staffing change. A master list is kept at the main nursing station and with the Administrator.
- *Person Responsible:* Administrator
- *Completion Date:* List updated 10/08/2025.

- The start date was 11/3/2025

- The updated list will be updated every 2 weeks on a Monday

Licensee's Proposed Overall Completion Date: 11/24/2025

Evidence of Completion

Implemented [REDACTED] 03/30/2026)

See attached.

63a - First Aid/CPR Training

8. 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 [REDACTED], during the 11:00 PM to 7:00 AM shift and 3:00 PM to 11:00 PM shift, 51 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [REDACTED], during the 11:00 PM to 7:00 AM shift and 3:00 PM to 11:00 PM shift, 51 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action:* The staff schedule has been revised to ensure a minimum of two CPR/First Aid certified staff are present on all shifts when resident count is 51 or above.
- *Systemic Change:* The scheduling manager will run a daily "CPR Coverage Report" to verify compliance before posting the schedule.
- *Person Responsible:* DON/ Scheduling Manager
- *Completion Date:* Schedule compliant as of 10/15/2025.

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate when the daily CPR Coverage report will begin.

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action:* The staff schedule has been revised to ensure a minimum of two CPR/First Aid certified staff are present on all shifts when resident count is 51 or above.
- *Systemic Change:* The scheduling manager will run a daily "CPR Coverage Report" to verify compliance before posting the schedule.
- *Person Responsible:* DON/ Scheduling Manager
- *Completion Date:* Schedule compliant as of 10/15/2025.

-the scheduling manager and the DON will be trained to keep track of when staff needing CPR and First aid are due for renewal.

- the scheduling manager will run a report to assure compliance with staffing CPR coverage daily.

- CPR daily coverage report will start by 12/01/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion**Implemented** [REDACTED] 03/30/2026)

See attached.

65a - FS Orientation 1st Day**9. 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.
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 C, whose first day of work was [REDACTED] did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services.

Repeat violation: [REDACTED] et al, and [REDACTED]

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* Facility located original document confirming that Staff Person C received the completed Fire Safety and Emergency Preparedness orientation on 9/29/2025.
- *Systemic Change:* Scheduling Manager will maintain tracking tool confirming Fire Safety and Emergency Preparedness orientation is completed prior to facility and agency staff providing direct care.
- *Person Responsible:* Administrator/Scheduling Manager
- *Completion Date:* Corrected 10/10/2025; Tracking tool implemented 10/15/2025.

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate any initial audits done on all employee files to ensure all have required training correctly documented in file. Include a specific date for the initial audit.

Please indicate the specific method to audit or monitor for ongoing compliance with new employees.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* Facility located original document confirming that Staff Person C received the completed Fire Safety and Emergency Preparedness orientation on 9/29/2025.
- *Systemic Change:* Scheduling Manager will maintain tracking tool confirming Fire Safety and Emergency Preparedness orientation is completed prior to facility and agency staff providing direct care.
- *Person Responsible:* Administrator/Scheduling Manager
- *Completion Date:* Corrected 10/10/2025; Tracking tool implemented 10/15/2025.

- The Scheduling manager will audit new staff for compliance with evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency

65a FS Orientation 1st Day (continued)

location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services.

A staff audit will be done on all employees monthly to assure compliance.

Hiring manager and HR will do a monthly audit of staff and staff training to keep up with compliance.

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented () - 03/30/2026)

See attached.

65d Initial Direct Care Training**10. Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
 - v. The normal aging cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person D, hired on [REDACTED], began providing unsupervised ADL services on [REDACTED]. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice.

Direct care staff person E, hired on [REDACTED], began providing unsupervised ADL services on [REDACTED]. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice.

Repeat violation: [REDACTED] et al, and [REDACTED]

65d - Initial Direct Care Training (*continued*)**Plan of Correction****Do Not Accept** [REDACTED] 11/17/2025)

- *Corrective Action: Staff Persons D and E have been assigned a preceptor and are undergoing supervised practice.*
- *Systemic Change: The "New Hire Orientation Checklist" includes a section for preceptor sign-off on demonstrated competency before unsupervised care is permitted.*
- *Person Responsible: DON/HR Director*
- *Completion Date: Retraining completed by 11/10/2025*

Licensee's Proposed Overall Completion Date: 11/14/2025**Update:** 11/17/2025*Please indicate any specific education to be provided for those persons responsible for ongoing compliance.**Please indicate any initial audits done on all employee files to ensure all have required training correctly documented in file. Include a specific date for the initial audit.**Please indicate the specific method to audit or monitor for ongoing compliance with new employees.***Plan of Correction****Accept** [REDACTED] - 12/04/2025)

- *Corrective Action: Staff Persons D and E have been assigned a preceptor and are undergoing supervised practice.*
- *Systemic Change: The "New Hire Orientation Checklist" includes a section for preceptor sign-off on demonstrated competency before unsupervised care is permitted.*
- *Person Responsible: DON/HR Director*
- *Completion Date: Retraining completed by 11/10/2025*

*- Staff is to have all education they need to be compliant and must be able to demonstrate job duties prior to working independently.**- HR director and DON are to keep track of staff training and compliance. All staff is required to receive the training they need to be compliant prior to working on the floor independently.**-HR to use the new hire Orientation Training to track the required training.***Licensee's Proposed Overall Completion Date:** 12/01/2025**Evidence of Completion****Implemented** [REDACTED] - 03/30/2026)*See attached.*

65e - 12 Hours Annual Training

11. Requirements

2600.

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

Description of Violation*Direct care staff person A received 0 hours of annual training in training year 2024.***Plan of Correction****Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action: Staff Person A no longer works for the facility.*
- *Systemic Change: A training tracker has been implemented to monitor all staff's annual training hours, with alerts sent 30 days prior to their due date.*
- *Person Responsible: Administrator / HR Director*
- *Completion Date: Annual Training tracker implemented 11/7/2025*

65e - 12 Hours Annual Training (continued)

Licensee's Proposed Overall Completion Date: 12/01/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate any initial audits done on all employee files to ensure all have required training correctly documented in file. Include a specific date for the initial audit.

Please indicate the specific method to audit or monitor for ongoing compliance with new employees.

Plan of Correction

Accept () - 12/04/2025)

- *Corrective Action: Staff Person A no longer works for the facility.*
- *Systemic Change: A training tracker has been implemented to monitor all staff's annual training hours, with alerts sent 30 days prior to their due date.*
- *Person Responsible: Administrator / HR Director*
- *Completion Date: Annual Training tracker implemented 11/7/2025*

- *Initial audit was completed by HR on 11/7/2025*

- *HR director and the DON will be educated on what is the required training needed by staff to stay compliant.*

- *HR director and the DON will have an audit of annual trainings needed by staff to stay complaint.*

- *Staff training audit will be completed by the HR manager and the DON monthly.*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented () - 03/30/2026)

See attached.

65i - Training Record

12. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care initial orientation staff training does not include the length of each course.

Repeat violation: () et al

Plan of Correction

Do Not Accept () 11/17/2025)

- *Corrective Action: All training records have been updated to include the precise length of each course.*
- *Systemic Change: Facility will utilize DHS website provider resources Model Form – Record of Training for future staff training modules.*
- *Person Responsible: Administrator / DON/ HR Director*
- *Completion Date: Records updated by 11/09/2025*

Licensee's Proposed Overall Completion Date: 12/01/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

65i - Training Record (continued)

Please indicate any initial audits done on all employee files/training documents to ensure all have correct documentation on file. Include a specific date for the initial audit.

Please indicate the specific method to audit or monitor for ongoing compliance with new employees.

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action:* All training records have been updated to include the precise length of each course.
- *Systemic Change:* Facility will utilize DHS website provider resources Model Form – Record of Training for future staff training modules.
- *Person Responsible:* Administrator / DON/ HR Director
- *Completion Date:* Records updated by 11/09/2025

- The DON and the HR director will be educated on the DHS website and where to look for the resources needed for staff training and compliance.

- HR director and the DON will have an audit they will complete monthly to assure all staff is compliant with training. Audit to be completed by 12/1/2025

- The HR director to complete a staff file audit on all staff

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

See attached.

66a - Staff Training Plan**13. Requirements**

2600.

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

Description of Violation

The home does not have a staff training plan for [REDACTED]

Plan of Correction**Accept** [REDACTED] 11/17/2025)

- *Corrective Action:* An annual Staff Training Plan for 11/01/2025 - 12/31/2026 has been developed and implemented.
- *Systemic Change:* The Training Plan is a standing agenda item for the QMP committee to ensure adherence and relevance.
- *Person Responsible:* Administrator
- *Completion Date:* Plan implemented 11/05/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

See attached.

81a - Accommodation**14. Requirements**

2600.

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

81a - Accommodation (continued)

Description of Violation

There are 3 residents in the home that are using bedside mobility devices. The home did not have a policy for the safe use of bedside mobility devices.

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action: A policy for the safe use of bedside mobility devices has been developed and implemented.*
- *Systemic Change: The policy is included in annual training. Resident support plans for those using these devices now specifically reference the policy and individual safety measures.*
- *Person Responsible: DON / Physical Therapist*
- *Completion Date: Policy implemented 11/9/2025.*

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action: A policy for the safe use of bedside mobility devices has been developed and implemented.*
- *Systemic Change: The policy is included in annual training. Resident support plans for those using these devices now specifically reference the policy and individual safety measures.*
- *Person Responsible: DON / Physical Therapist*
- *Completion Date: Policy implemented 11/9/2025.*

- The DON will be educated on the proper use of the mobility devices and the policy and will educate the residents on proper use of the device.

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

See attached.

82c - Locking Poisonous Materials

15. 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

A bar of Safeguard soap, with a manufacture's label indicating "In case of accidental ingestion, seek medical attention or contact a poison control center immediately.", was unlocked, unattended, and accessible to residents in Secure Dementia Care Unit (SDCU) room [REDACTED] which was open and unlocked at the time of inspection. Not all the residents of the home, including resident [REDACTED] have been assessed as capable of recognizing and using poisons safely.

Repeat violation: [REDACTED] et al.

82c - Locking Poisonous Materials (continued)

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: The Safeguard soap was removed from the unsecured room. An audit of all resident rooms and common areas was conducted to remove any unsecured poisonous materials.*
- *Systemic Change: All cleaning supplies and poisonous materials are now stored in a central, locked storage closet. Environmental services staff have been trained on this policy.*
- *Person Responsible: Director of Nursing/Housekeeping Director/ Maintenance Director*
- *Completion Date: Audit completed 10/09/2025*

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: The Safeguard soap was removed from the unsecured room. An audit of all resident rooms and common areas was conducted to remove any unsecured poisonous materials.*
- *Systemic Change: All cleaning supplies and poisonous materials are now stored in a central, locked storage closet. Environmental services staff have been trained on this policy.*
- *Person Responsible: Director of Nursing/Housekeeping Director/ Maintenance Director*
- *Completion Date: Audit completed 10/09/2025*

- *on 11/14/2025 a Inservice was completed,*
- *weekly rounds initiated on 11/14/2025 to be completed by the DON or floor nurse.*

Licensee's Proposed Overall Completion Date: 11/24/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

85a - Sanitary Conditions

16. Requirements

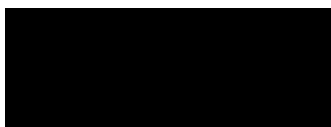
2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident [REDACTED] has an order for Glucose checks to be completed twice daily at 0800 and 1700, with insulin coverage according to a sliding scale. On [REDACTED] resident [REDACTED] went on an extended leave of absence from the home and had not returned as of [REDACTED].

During inspection of the home on [REDACTED], Resident [REDACTED] glucometer had the following readings recorded:



Resident 6 has an order for glucose checks to be completed 4 times daily at 0800, 1200, 1700, and 2000 with insulin

85a - Sanitary Conditions (continued)

coverage according to a sliding scale.

Resident's [REDACTED] glucometer was used to take readings for resident 6 on at least two occasions.

On [REDACTED], a glucose level of [REDACTED] was recorded on resident [REDACTED]'s glucose log/medication administration record (MAR), however there was no corresponding reading found in resident [REDACTED] glucometer. This reading of [REDACTED] was found to have been recorded on resident [REDACTED] glucometer.

On [REDACTED] a glucose reading of [REDACTED] was documented on Resident [REDACTED] glucose log/medication administration record, however there was no corresponding reading in resident [REDACTED] glucometer. On [REDACTED] at 9:25 PM a reading of [REDACTED] was found on resident [REDACTED]'s glucometer, this number was not documented on resident [REDACTED]'s glucose log/medication administration record.

Repeat Violations: [REDACTED] et al.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* Resident [REDACTED] glucometer has been removed from service and cleaned. Staff were re-educated on the policy of never sharing glucometers between residents.
- *Systemic Change:* Each resident with a glucose order is now assigned their own labeled glucometer. The charge nurse audits compliance weekly.
- *Person Responsible:* DON
- *Completion Date:* Corrected 10/08/2025; Audit process implemented 10/15/2025

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate the date of education provided for those persons responsible for ongoing compliance.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* Resident 5's glucometer has been removed from service and cleaned. Staff were re-educated on the policy of never sharing glucometers between residents.
- *Systemic Change:* Each resident with a glucose order is now assigned their own labeled glucometer. The charge nurse audits compliance weekly.
- *Person Responsible:* DON
- *Completion Date:* Corrected 10/08/2025; Audit process implemented 10/15/2025

- Training was provided on 11/14/2025

Licensee's Proposed Overall Completion Date: 11/24/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

17. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

85a Sanitary Conditions (continued)

Description of Violation

On [REDACTED] at 11:04 AM, an Arnuity inhaler, and a bag containing an insulin injection pen were found in the top of drawer of the memory care medication cart with a light brown substance, possibly peanut butter smeared on the sides.

Plan of Correction**Do Not Accept** [REDACTED] 11/17/2025)

- *Corrective Action:* The medication cart was immediately cleaned and sanitized. The inhaler and insulin pen were cleaned and checked for integrity.
- *Systemic Change:* A policy requires that medication carts be wiped down with disinfectant at the beginning and end of every shift. The DON conducts random spot checks.
- *Person Responsible:* DON
- *Completion Date:* Corrected 10/07/2025; Policy reinforced 10/08/2025

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action:* The medication cart was immediately cleaned and sanitized. The inhaler and insulin pen were cleaned and checked for integrity.
- *Systemic Change:* A policy requires that medication carts be wiped down with disinfectant at the beginning and end of every shift. The DON conducts random spot checks.
- *Person Responsible:* DON
- *Completion Date:* Corrected 10/07/2025; Policy reinforced 10/08/2025

- Staff education on the med cart sanitation was provided on 11/14/2025
- DON and Administrator to conduct weekly spot checks of the cart.
- spot checks to start on 11/24/2025 done by the DON

Licensee's Proposed Overall Completion Date: 11/24/2025

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

See attached.

85d - Trash Receptacles

18. 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 10:32 AM there was a 3/4 full, uncovered, unattended trash can in the kitchen with disposable cups and food debris. Staff in the area was interviewed and said the trashcan was not in use.

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action:* The uncovered trash can in the kitchen was covered immediately.

85d - Trash Receptacles (continued)

- *Systemic Change: All trash receptacles in kitchens and bathrooms will be covered when not in use. Housekeeping staff will check them during rounds.*
- *Person Responsible: Housekeeping Director*
- *Completion Date: Corrected 10/06/2025*

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accepted [REDACTED] - 12/04/2025)

- *Corrective Action: The uncovered trash can in the kitchen was covered immediately.*
 - *Systemic Change: All trash receptacles in kitchens and bathrooms will be covered when not in use. Housekeeping staff will check them during rounds.*
 - *Person Responsible: Housekeeping Director*
 - *Completion Date: Corrected 10/06/2025*
- *The Housekeeping manager is to be educated on the Trash receptacles and the policy to keep up with compliance.*
- *daily spot checks completed by the housekeeping staff. Staff to complete the audit during daily rounds to start on 12/1/2025*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

85e - Trash Outside Home**19. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [REDACTED] at 10:19 AM the dumpster outside the home was filled and the lids were not in place.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: The dumpster was emptied, and the lids were secured on 10/06/2025.*
- *Systemic Change: The maintenance team will check the dumpster lids daily as part of their closing rounds. The trash hauler has been notified to ensure lids are replaced after pickup.*
- *Person Responsible: Maintenance Director*
- *Completion Date: Corrected 10/06/2025*

85e - Trash Outside Home (continued)

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: The dumpster was emptied, and the lids were secured on 10/06/2025.*
- *Systemic Change: The maintenance team will check the dumpster lids daily as part of their closing rounds. The trash hauler has been notified to ensure lids are replaced after pickup.*
- *Person Responsible: Maintenance Director*
- *Completion Date: Corrected 10/06/2025*

- *The trash company was educated on the importance of keeping the lid closed on the dumpster.*
- *The maintenance director is to do daily spot checks to assure the dumpster lid is closed*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

88a - Surfaces

20. 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 10:05 AM, the chaplain/activity room was left unlocked in the SDCU. The room contained a large manual paper cutter. This is a hazard to the memory care residents. Above the paper cutter, the ceiling was stained with a brown ring and black specs which appear to be mold.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: The paper cutter was removed from the unlocked chaplain/activity room. The ceiling has been assessed by Maintenance and repaired.*
- *Systemic Change: All activity rooms in the SDCU are now locked when not in use or under direct staff supervision. A preventive maintenance schedule for room inspections has been implemented.*
- *Person Responsible: Maintenance Director / Administrator*
- *Completion Date: Paper cutter removed 10/06/2025; Ceiling repair completed 10/7/2025.*

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: The paper cutter was removed from the unlocked chaplain/activity room. The ceiling has been*

88a Surfaces (continued)

assessed by Maintenance and repaired.

- *Systemic Change: All activity rooms in the SDCU are now locked when not in use or under direct staff supervision. A preventive maintenance schedule for room inspections has been implemented.*
- *Person Responsible: Maintenance Director / Administrator*
- *Completion Date: Paper cutter removed 10/06/2025; Ceiling repair completed 10/7/2025.*

Activities staff is to be educated on keeping the activity office door closes when not in use.

The Activities staff are to do daily spot checks at the beginning and end of the shift to assure all safety hazards are put away and doors are locked when office not in use.

Start date is 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] 03/30/2026)

See attached.

90b Staff Communication**21. Requirements**

2600.

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency. On [REDACTED] at 11:01 AM, the home served 53 residents. When staff person C needed assistance accessing resident MARs, staff person C did not know how to communicate with staff on the other side of the building. Staff person C stated [REDACTED] would walk to the other side for the building to look for someone because [REDACTED] was not trained on how to use the phone system.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: All staff will be trained in the use of the facility's phone system for internal communication.*
- *Systemic Change: Operational Instruction cards will be placed at nursing unit phones for staff reference. Administrator will conduct staff audits to confirm operational aptitude.*
- *Person Responsible: Administrator*
- *Completion Date: 11/13/2025*

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate when specific education was provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: All staff will be trained in the use of the facility's phone system for internal communication.*
- *Systemic Change: Operational Instruction cards will be placed at nursing unit phones for staff reference. Administrator will conduct staff audits to confirm operational aptitude.*
- *Person Responsible: Administrator*

90b - Staff Communication (continued)

• Completion Date: 11/13/2025

- Signs with specific instruction were placed by each phone on 11/14/2025 and staff was educated on the instructions.

- Daily spot check to ensure sign is in place and to be replaced if needed completed by the DON and the floor nurse

Licensee's Proposed Overall Completion Date: 11/24/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

91 - Telephone Numbers**22. 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, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline on or by the telephone in rooms [REDACTED] and [REDACTED].

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- Corrective Action: Emergency telephone numbers have been posted on or by the telephones in rooms B204 and A102.
- Systemic Change: The Maintenance Director audited all telephones in the facility to ensure compliance. This is now part of the monthly environmental safety audit.
- Person Responsible: Maintenance Director
- Completion Date: 11/9/2025.

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- Corrective Action: Emergency telephone numbers have been posted on or by the telephones in rooms B204 and A102.
- Systemic Change: The Maintenance Director audited all telephones in the facility to ensure compliance. This is now part of the monthly environmental safety audit.
- Person Responsible: Maintenance Director
- Completion Date: 11/9/2025.

- Staff to be educated in looking for the telephone numbers needed to be placed on or by the phones which are the emergency telephone number residents may need.

Licensee's Proposed Overall Completion Date: 12/01/2025

91 - Telephone Numbers (*continued*)**Evidence of Completion**

See attached.

Implemented [REDACTED] - 03/30/2026)

95 - Furniture and Equipment

23. Requirements

2600.

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

Description of Violation

On [REDACTED] at 10:02 AM toilet paper roll holder in room [REDACTED] was missing.

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action: The toilet paper roll holder in room C312 has been repaired.*
- *Systemic Change: A work order system has been implemented. Housekeeping and nursing staff are instructed to report any maintenance issues immediately.*
- *Person Responsible: Maintenance Director*
- *Completion Date: Corrected 10/07/2025.*

Licensee's Proposed Overall Completion Date: 11/10/2025**Update:** 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action: The toilet paper roll holder in room C312 has been repaired.*
- *Systemic Change: A work order system has been implemented. Housekeeping and nursing staff are instructed to report any maintenance issues immediately.*
- *Person Responsible: Maintenance Director*
- *Completion Date: Corrected 10/07/2025.*

- Education was provided to staff on 11/14/2024 on how to communicate with maintenance if a work order needs to be submitted.

- A Maintenance log was provided at the nursing Staton for nursing staff to use daily to communicate any concerns on a daily basis.

Licensee's Proposed Overall Completion Date: 12/01/2025**Evidence of Completion**

See attached.

Implemented [REDACTED] - 03/30/2026)

96b - First Aid Location

24. Requirements

2600.

96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff persons E and G

96b - First Aid Location (continued)

, did not know the location of the home's first aid kit.

Plan of Correction

Accept () - 11/17/2025)

- *Corrective Action:* Staff Persons E and G were immediately shown the location of all first aid kits and can now verbally state their locations.
- *Systemic Change:* The location of the first aid kit is now a verified item on the "First Day Orientation Checklist" and is reviewed annually with all staff.
- *Person Responsible:* DON/HR Director
- *Completion Date:* Corrected 10/08/2025

Licensee's Proposed Overall Completion Date: 11/07/2025

Evidence of Completion

Implemented () - 03/30/2026)

See attached.

102i - Soap Dispenser**25. Requirements**

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled used bar of soap in shared room ()

Plan of Correction

Do Not Accept () - 11/17/2025)

- *Corrective Action:* The unlabeled bar of soap was removed from shared room C307.
- *Systemic Change:* Staff will be instructed to remove all bar soap from shared bathrooms. Supplies will be delivered and removed from resident rooms to accommodate service needs and avoid injury to residents.
- *Person Responsible:* DON/Housekeeping Director/Maintenance
- *Completion Date:* Corrected 10/06/2025

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept () - 12/04/2025)

- *Corrective Action:* The unlabeled bar of soap was removed from shared room C307.
- *Systemic Change:* Staff will be instructed to remove all bar soap from shared bathrooms. Supplies will be delivered and removed from resident rooms to accommodate service needs and avoid injury to residents.
- *Person Responsible:* DON/Housekeeping Director/Maintenance
- *Completion Date:* Corrected 10/06/2025

- Staff was educated on 11/14/2025 on leaving things in residents' rooms. All items are to be put away and locked.
- The DON and the PCHA will conduct random room check to keep up with compliance.
- Random room checks to start on 12/1/2025

102i - Soap Dispenser (continued)

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

See attached.

Implemented () - 03/30/2026)

124 - Notice to Fire Department**26. Requirements**

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Repeat violation: ()

Plan of Correction

Accept () - 11/17/2025)

- *Corrective Action:* Written notification has been sent to the local fire department with the required information.
- *Systemic Change:* This notification will be updated annually and upon any renovation that changes bedroom locations. Documentation is kept in the facility's emergency preparedness binder.
- *Person Responsible:* Administrator
- *Completion Date:* Notification sent 11/9/2025.

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

Evidence of Completion

See attached.

Implemented () - 03/30/2026)

141a 1-10 Medical Evaluation Information**27. 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 () medical evaluation was completed on () The resident's medical evaluation did not include a

141a 1-10 Medical Evaluation Information (continued)

general physical examination by a physician, physician's assistant or nurse practitioner.

Plan of Correction

Do Not Accept [REDACTED] 11/17/2025)

- *Corrective Action:* Resident 1's physician has been contacted to complete and return the missing component (general physical examination) of the medical evaluation.
- *Systemic Change:* The admissions coordinator now uses a checklist to review all incoming medical evaluations for completeness before filing.
- *Person Responsible:* DON / Admissions Coordinator
- *Completion Date:* Awaiting physician response; Follow-up weekly until complete. Checklist implemented 10/15/2025

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate the specific method to audit or monitor for initial overall compliance and for ongoing compliance.
Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* Resident [REDACTED] physician has been contacted to complete and return the missing component (general physical examination) of the medical evaluation.
- *Systemic Change:* The admissions coordinator now uses a checklist to review all incoming medical evaluations for completeness before filing.
- *Person Responsible:* DON / Admissions Coordinator
- *Completion Date:* Awaiting physician response; Follow-up weekly until complete. Checklist implemented 10/15/2025

- The DON and the admissions coordinator to be educated on the forms and how to keep compliant.
- The admissions coordinator will have a move in audit/check list to keep up with compliance.
- Audit to be completed prior to a new move in.
- Audit started on 10/15/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

161b - Well-Balanced Meals

28. Requirements

2600.

161.b. At least three nutritionally well-balanced meals shall be offered daily to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

Description of Violation

On [REDACTED] resident [REDACTED] was interviewed. Resident [REDACTED] stated that alternatives to meals are not given and so [REDACTED] buys [REDACTED] own food or has someone bring [REDACTED] other meals.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

161b Well Balanced Meals (continued)

- *Corrective Action: The Dietary Manager interviewed Resident 7 and ensured they understood how to request meal alternatives.*
- *Systemic Change: Menus provide alternative options "Always Available" for each meal. Staff are trained to verbally offer alternatives to residents during meal service.*
- *Person Responsible: Dietary Manager/Administrator/DON*
- *Completion Date: 10/9/2025*

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance, such as random interviews with residents and staff to ensure understanding of menu options, etc. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] 12/04/2025)

- *Corrective Action: The Dietary Manager interviewed Resident 7 and ensured they understood how to request meal alternatives.*
- *Systemic Change: Menus provide alternative options "Always Available" for each meal. Staff are trained to verbally offer alternatives to residents during meal service.*
- *Person Responsible: Dietary Manager/Administrator/DON*
- *Completion Date: 10/9/2025*

-The Dining director to educate [REDACTED] staff in compliance and to offer alternative meals to residents that wish to have them.

- Dining manager will make random visits with the residents and interview the residents and offer menu options of their liking. The visits will start 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

161c - Additional Portions**29. Requirements**

2600.

161.c. Additional portions of meals and beverages at mealtimes shall be available for the resident.

Description of Violation

On [REDACTED] at the breakfast meal, there were no additional portions of milk available for residents. Resident [REDACTED] was provided with one small carton of milk for [REDACTED] breakfast of cheerios, and was denied an additional carton when requested.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: The Dietary Manager confirmed that additional milk portions are always available and*

161c Additional Portions (continued)

reinforced with serving staff that additional servings should be accommodated when requested.

- *Systemic Change: Dietary staff will be educated to provide additional milk portions when request is appropriate.*
- *Person Responsible: Dietary Manager/Administrator/DON*
- *Completion Date: 11/14/2025.*

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate the specific method to audit or monitor for ongoing compliance, such as random interviews with residents and staff to ensure understanding of menu options, etc. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: The Dietary Manager confirmed that additional milk portions are always available and reinforced with serving staff that additional servings should be accommodated when requested.*
- *Systemic Change: Dietary staff will be educated to provide additional milk portions when request is appropriate.*
- *Person Responsible: Dietary Manager/Administrator/DON*
- *Completion Date: 11/14/2025.*

- *Dining supervisor will educate staff on how to go about getting extra portions for the residents.*

- *Dining manager and the DON will do random check ins in the dining room to assure compliance. Random dining room visits to start 12/1/2025*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

182b - Prescription Medication**30. Requirements**

2600.

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

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [REDACTED] to [REDACTED] at 8:00 AM staff person D administered medications to residents to include the following; [REDACTED] tablet to Resident [REDACTED]. Staff person D is not 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

182b - Prescription Medication (continued)

injections for insect bites or other allergies.

The staff person did complete medication administration training on 2/26/2025, however the trainer who facilitated the training did not meet the required qualifications of the Department's "Train the Trainer" certification, making staff person D's training invalid.

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action: Staff Person D has been removed from medication administration duties. A nurse reviewed all medications they administered for errors.*
- *Systemic Change: All medication aides will be re-trained by a department-approved trainer. The DON must verify trainer credentials and staff competency before they are cleared to administer medications.*
- *Person Responsible: DON/HR Director*
- *Completion Date: Staff Person D removed 10/08/2025; Retraining to be completed by 12/01/2025*

Licensee's Proposed Overall Completion Date: 12/01/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action: Staff Person D has been removed from medication administration duties. A nurse reviewed all medications they administered for errors.*
- *Systemic Change: All medication aides will be re-trained by a department-approved trainer. The DON must verify trainer credentials and staff competency before they are cleared to administer medications.*
- *Person Responsible: DON/HR Director*
- *Completion Date: Staff Person D removed 10/08/2025; Retraining to be completed by 12/01/2025*

- Med techs will be retrained when a trainer is located and secured to conduct training, LPNs have been put in place to replace med techs.

- Plan in place to hire more LPNs to replace med techs.

- Hiring of LPNs to start 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

LPNs to replace Med tech when hired

183b - Meds and Syringes Locked**31. 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.

183b Meds and Syringes Locked (*continued*)**Description of Violation**

On [REDACTED] at 9:41 AM, the medication room behind the nurse's station was propped open with a trash can. There were no staff members in the area, leaving all resident overflow medications unlocked, unattended, and accessible.

Repeat violation: [REDACTED] et al.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* The medication room door is no longer propped open. All medications are secured.
- *Systemic Change:* Staff education will be ongoing. Individual Medication room key obtained for Extra Nurse on dayshift. DON will conduct random audits to verify compliance
- *Person Responsible:* DON/Administrator
- *Completion Date:* Corrected 10/07/2025.

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

Update: 11/17/2025

Please indicate specific start date for education to be provided for those persons responsible for ongoing compliance.

Please indicate the specific method to audit or monitor for ongoing compliance, etc. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* The medication room door is no longer propped open. All medications are secured.
- *Systemic Change:* Staff education will be ongoing. Individual Medication room key obtained for Extra Nurse on dayshift. DON will conduct random audits to verify compliance
- *Person Responsible:* DON/Administrator
- *Completion Date:* Corrected 10/07/2025.

- Staff was trained on 11/14/2025 on keeping the door closed and locked.
- The DON and the PCHA will do spot checks weekly.
- Key was made and given to the day nurse so [REDACTED] can keep the door locked. Key given on 11/14/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

183d - Prescription Current

32. 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], [REDACTED] prescribed for resident [REDACTED] was in the home's medication room; however, the resident passed away on [REDACTED].

183d - Prescription Current (continued)

On [REDACTED] give twice a day for 7 days prescribed for resident [REDACTED] was in the home's medication cart; however, the medication was discontinued on [REDACTED]

[REDACTED] give 1 twice daily for 10 days, prescribed for resident [REDACTED], was in the home's medication cart; however, the medication was discontinued on [REDACTED].

Repeat violation [REDACTED]

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

- *Corrective Action: The medications for Residents 6, 8, and 9 (deceased) were disposed of according to policy.*
- *Systemic Change: The weekly "Medication Cart Audit" now includes a check for discontinued or deceased residents' medications.*
- *Person Responsible: DON / Administrator*
- *Completion Date: Corrected 10/08/2025; Weekly audits ongoing*

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

Update: 11/17/2025

*Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate the specific method to audit or monitor for ongoing compliance, etc. Include specific start dates, frequencies, titles of persons responsible, etc.*

Plan of Correction**Accept** [REDACTED] - 12/04/2025)

- *Corrective Action: The medications for Residents 6, 8, and 9 (deceased) were disposed of according to policy.*
- *Systemic Change: The weekly "Medication Cart Audit" now includes a check for discontinued or deceased residents' medications.*
- *Person Responsible: DON / Administrator*
- *Completion Date: Corrected 10/08/2025; Weekly audits ongoing*

- *LPNs and med techs were educated on 11/14/2025 concerning meds and med disposal.*
- *Daily spot checks to be conducted by the office nurse and the DON to assure compliance.*
- *Spot checks to start on 12/1/2025*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

See attached.

183e - Storing Medications

33. Requirements

2600.

183e - Storing Medications (continued)

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] there was a loose large white pill found in the second drawer of the memory care medication cart.

A [REDACTED] for resident [REDACTED] was undated, and Humalog insulin pen for resident [REDACTED] were both dated as opened on [REDACTED]. Both were found in the home's medications carts on [REDACTED]. According to the manufacturer's instructions the unused portion of this medication must be discarded 28 days after opening.

Resident [REDACTED] is prescribed [REDACTED] take 1 pill every 4 hours as needed. This medication was stored in small unlabeled plastic bags that are used to crush pills. The bags had approximately 10 pills in each bag, and the bags were then stored in a pill bottle, and then in another plastic bag. Multiple pills in each of these small bags were cracked, chipped or broken.

A blister pack of [REDACTED], prescribed for resident [REDACTED] was in the home's medication cart on [REDACTED]. This medication expired on [REDACTED].

A blister of [REDACTED] for resident [REDACTED] was taped over at spot 30, and had a tear in the foil at spot 5, the pills remained inside the packaging.

A bottle of unopened Latanoprost eye drops for resident [REDACTED] was stored in the home's medication cart at room temperature. According to the manufacturer's instructions this medication must be refrigerated until opened.

Resident [REDACTED]'s Arnuity inhaler was opened and undated. According to the manufacturer's instructions the unused medication must be discarded 6 weeks after opening.

Repeat violation: [REDACTED] et al and [REDACTED].

Plan of Correction**Do Not Accept [REDACTED] - 11/17/2025)**

- *Corrective Action:* The loose pill was disposed of. Expired and improperly stored insulin, inhalers, and eye drops were replaced or properly stored.
- *Systemic Change:* The weekly medication audit includes checks for expiration dates, integrity of packaging, and compliance with manufacturer storage instructions.
- *Person Responsible:* DON / Administrator
- *Completion Date:* Audit and correction completed 10/08/2025

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Plan of Correction**Accept [REDACTED] - 12/04/2025)**

- *Corrective Action:* The loose pill was disposed of. Expired and improperly stored insulin, inhalers, and eye drops were replaced or properly stored.

183e - Storing Medications (continued)

- *Systemic Change: The weekly medication audit includes checks for expiration dates, integrity of packaging, and compliance with manufacturer storage instructions.*
- *Person Responsible: DON / Administrator*
- *Completion Date: Audit and correction completed 10/08/2025*

- *Med techs and LPNs were educated on 11/14/2025 about staying compliant with the medications and med carts and med cart audits.*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 03/30/2026)

184a - Resident's Meds Labeled**34. Requirements**

2600.

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

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

Description of Violation

The pharmacy label for resident [REDACTED] bottle says Take one tablet by mouth nightly,, however, the resident's order had been changed on [REDACTED] to take 1/2 a tablet at bedtime. There was no change of direction sticker on this medication to indicate new instructions.

Repeat violation: [REDACTED]

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: The pharmacy was contacted to provide a new label for Resident 6's quetiapine.*
- *Systemic Change: Nurses are instructed to contact the pharmacy immediately for a new label upon any change in orders, and not to use "change of direction" stickers as a permanent solution.*
- *Person Responsible: DON/Administrator*
- *Completion Date: New label received 10/15/2025*

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] 12/04/2025)

- *Corrective Action: The pharmacy was contacted to provide a new label for Resident 6's quetiapine.*
- *Systemic Change: Nurses are instructed to contact the pharmacy immediately for a new label upon any change*

184a - Resident's Meds Labeled (continued)

in orders, and not to use "change of direction" stickers as a permanent solution.

- Person Responsible: DON/Administrator
- Completion Date: New label received 10/15/2025

- The med techs and LPNs were educated on 11/14/2025 on how to stay compliant with over-the-counter medications and how to label med changes.

- LPNs and Med tech are to complete cart audits daily. Start day for cart audits 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 03/30/2026)

184b - Labeling OTC/CAM**35. 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] a package of Phillips laxative tablets belonging to resident 6 was in the home's medication cart and was not labeled with the resident's name.

A bottle of Advil was unlabeled in the home's memory care medication cart; the home could not determine who this medication belonged to.

Repeat violation: [REDACTED] et al.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- Corrective Action: The unlabeled Advil was disposed of. Resident 6's laxatives were labeled.
- Systemic Change: The weekly medication audit includes a check that all OTC medications and CAM are labeled with the resident's name.
- Person Responsible: DON / Administrator
- Completion Date: Corrected 10/08/2025.

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate the specific start dates for the audits.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- Corrective Action: The unlabeled Advil was disposed of. Resident 6's laxatives were labeled.
- Systemic Change: The weekly medication audit includes a check that all OTC medications and CAM are labeled with the resident's name.
- Person Responsible: DON / Administrator
- Completion Date: Corrected 10/08/2025.

184b - Labeling OTC/CAM (continued)

- LPNs and med techs were educated on 11/14/2025 on how to stay compliant with medications and med carts and how to do the med cart audits.
- weekly cart audits to start on 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 03/30/2026)

185a - Implement Storage Procedures**36. 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] at 11:30 AM, resident [REDACTED]'s glucometer was set to 8:29 AM.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* Resident [REDACTED] glucometer time was corrected to the current time.
- *Systemic Change:* The nurse on each shift is now responsible for verifying that all glucometers have the correct date and time during shift change.
- *Person Responsible:* DON / Administrator
- *Completion Date:* Corrected 10/07/2025; Procedure implemented 10/08/2025

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* Resident [REDACTED] glucometer time was corrected to the current time.
- *Systemic Change:* The nurse on each shift is now responsible for verifying that all glucometers have the correct date and time during shift change.
- *Person Responsible:* DON / Administrator
- *Completion Date:* Corrected 10/07/2025; Procedure implemented 10/08/2025

- LPNs and Med tech were educated on 11/14/2025 on how to stay compliant with keeping up with the glucometers and the glucometer audits.

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 03/30/2026)

37. Requirements

2600.

185a - Implement Storage Procedures (continued)

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] is prescribed [REDACTED] tablet as needed. On [REDACTED] this medications was not available in the home.

Resident [REDACTED] is prescribed [REDACTED], give twice daily as needed every 6 hours and [REDACTED] suspension, give 10 ml by mouth as needed every 8 hours. On [REDACTED], these medications were not available in the home.

Repeat violation [REDACTED]

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* The missing medications for Residents 3 and 8 were re-ordered and are now available in the home.
- *Systemic Change:* A "PRN and Stock Medication Inventory" is now completed weekly by the floor nurse to ensure adequate stock of all prescribed medications.
- *Person Responsible:* DON/Administrator
- *Completion Date:* Medications available 10/10/2025; Inventory process implemented 10/17/2025.

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.
Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* The missing medications for Residents 3 and 8 were re-ordered and are now available in the home.
- *Systemic Change:* A "PRN and Stock Medication Inventory" is now completed weekly by the floor nurse to ensure adequate stock of all prescribed medications.
- *Person Responsible:* DON/Administrator
- *Completion Date:* Medications available 10/10/2025; Inventory process implemented 10/17/2025.

- Med techs and LPN were educated on 11/14/2025 on cart audits and how to stay compliant with med availability and how to order meds.
- A cart audit and MAR audit will be completed by the med techs and LPNs weekly.

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

38. Requirements

2600.

185a Implement Storage Procedures (continued)

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] controlled substance inventory record for [REDACTED] tablets has the following discrepancies where the pill count is scribbled over on multiple lines and the pill counts did not correctly identify what was remaining or administered.



The home narcotic policy states "9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must count together. They must document and report any discrepancies to the director of nursing. 10. The director of nursing services shall investigate any discrepancies in the narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the administrator a report of such findings. "

The home did not follow their medications accountability policies and staff did not inform the proper persons of the discrepancy or complete a follow up investigation.

Repeat violation: [REDACTED] et al.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action:* The controlled substance record for Resident 13 has been corrected.
- *Systemic Change:* Mandatory dual nursing count of all controlled substances at every shift change, with immediate reporting of any discrepancy to the DON and Administrator.
- *Person Responsible:* DON / Administrator
- *Completion Date:* Dual count policy reinforced 10/08/2025.

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance, such as random interviews with residents and staff to ensure understanding of menu options, etc. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* The controlled substance record for Resident 13 has been corrected.
- *Systemic Change:* Mandatory dual nursing count of all controlled substances at every shift change, with

185a - Implement Storage Procedures (continued)

immediate reporting of any discrepancy to the DON and Administrator.

- *Person Responsible: DON / Administrator*
- *Completion Date: Dual-count policy reinforced 10/08/2025.*

- LPNs and med tech were educated on 11/14/2025 on compliance with controlled substances and to be clear with documenting and signing out meds.

- the LPNs and Med tech to continue with dual nursing count and the DON to do random checks.

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

See attached.

Implemented [REDACTED] - 03/30/2026)

187a - Medication Record**39. 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] is prescribed sliding scaled insulin [REDACTED]. Above [REDACTED] or below [REDACTED] notify doctor. However, resident's [REDACTED] medication administration record does not indicate the number of units administered on [REDACTED] at noon when the meter had a reading of [REDACTED].

Plan of Correction

Do Not Accept [REDACTED] 11/17/2025)

- *Corrective Action: Resident 6's MAR for 9/20/25 has been corrected to reflect the number of insulin units administered.*
- *Systemic Change: Weekly audit of the glucometer and MAR created to ensure MAR accuracy. The nurse is responsible to check the number on the glucometer and the number on the MAR for accuracy.*
- *Person Responsible: DON/Administrator*
- *Completion Date: MAR corrected 10/15/2025.*

187a - Medication Record (continued)

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action:* Resident 6's MAR for 9/20/25 has been corrected to reflect the number of insulin units administered.
- *Systemic Change:* Weekly audit of the glucometer and MAR created to ensure MAR accuracy. The nurse is responsible to check the number on the glucometer and the number on the MAR for accuracy.
- *Person Responsible:* DON/Administrator
- *Completion Date:* MAR corrected 10/15/2025.

LPNs and Med tech were educated on 11/14/2025 on the compliance of insulin and glucometers.

- Glucometer and MAR audits to be done weekly by the LPNs and med techs, to start on 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

187d - Follow Prescriber's Orders

40. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed sliding scale insulin coverage as follows:

[REDACTED]. Above [REDACTED] or below [REDACTED] notify doctor.

The following discrepancies were found when reviewing resident 6's glucometer and MAR:

- [REDACTED] at 17:00- the glucometer read [REDACTED] requiring to contact the doctor, however the medication administration record was documented as [REDACTED] with [REDACTED]. - there is no indication that the residents doctor was contacted.
- [REDACTED] at 20:00- the glucometer read [REDACTED] requiring to contact the doctor, however the medication administration record was documented as [REDACTED] with [REDACTED] units of insulin administered, there is no indication that the residents doctor was contacted.
- [REDACTED] at 17:00- the glucometer read [REDACTED] requiring to contact doctor, however the medication administration record was documented as [REDACTED] with [REDACTED] of insulin administered, there is no indication that the residents doctor was contacted.
- [REDACTED] at 20:00- the glucometer read [REDACTED] requiring [REDACTED], however the medication administration record was documented as [REDACTED] with [REDACTED] on insulin administered.

187d Follow Prescriber's Orders (continued)

On [REDACTED] resident 8 was prescribed to take [REDACTED] in the evening for anxiety. The resident had a current blister card package containing one [REDACTED] tablet in each blister spot. The label contained a sticker indicating that the directions had changed and to refer to the residents chart. Based on resident 8's controlled substance log [REDACTED] only received one 0.5 mg tablet each evening on [REDACTED] to [REDACTED], and [REDACTED] at 20:00.

on [REDACTED] Resident 8 was prescribed [REDACTED] give 1 twice daily for 10 days. Resident 8 was only administered this medication on [REDACTED] at 17:00 and [REDACTED] at 8:00.

Resident 8 was prescribed [REDACTED] give 1 tablet by mouth 2 times daily for 3 days, which was documented as administered [REDACTED] and [REDACTED] at 17:00 and [REDACTED] and [REDACTED] at 8:00. The package only contained a total of 6 pills to be administered, however, on [REDACTED], the resident's blister pack for this medication still contained 2 pills.

Repeat violation [REDACTED] and [REDACTED] et al

Plan of Correction

Do Not Accept [REDACTED] 11/17/2025)

- Corrective Action: The DON has reviewed the discrepancies with the involved staff.
- Systemic Change: A weekly audit of MAR and glucometer created to assure all numbers on the glucometer and MAR match. The nurse is to complete the weekly audit.
- Person Responsible: DON/Administrator
- Completion Date: Process implemented 10/20/2025.

Licensee's Proposed Overall Completion Date: 11/14/2025

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance, such as an initial audit of the cart/MAR's, ongoing audits etc. . Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] 12/04/2025)

- Corrective Action: The DON has reviewed the discrepancies with the involved staff.
- Systemic Change: A weekly audit of MAR and glucometer created to assure all numbers on the glucometer and MAR match. The nurse is to complete the weekly audit.
- Person Responsible: DON/Administrator
- Completion Date: Process implemented 10/20/2025.

- Med tech and LPNs were educated on 11/14/2025 on the MAR and glucometer audits
- MAR and glucometer audits to be completed weekly by LPNS and med techs. Audits to start on 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

191 - Resident Right to Refuse

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

Repeat violation: [REDACTED]

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: Resident 4 and POA were educated on the right to refuse medication.*
- *Systemic Change: Education on the right to refuse medication is now a required component of the initial resident rights review and is documented annually.*
- *Person Responsible: Admissions Coordinator/ DON*
- *Completion Date: 11/7/2025.*

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance. Please indicate the specific method to audit or monitor for ongoing compliance. Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: Resident 4 and POA were educated on the right to refuse medication.*
- *Systemic Change: Education on the right to refuse medication is now a required component of the initial resident rights review and is documented annually.*
- *Person Responsible: Admissions Coordinator/ DON*
- *Completion Date: 11/7/2025.*

- *Admissions Coordinator was educated on the audit and to complete it yearly*
- *The audit will be done at the time of move in and annually by the DON and Admissions Coordinator*
- *Audit will start on 12/1/2025*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

225c - Additional Assessment**42. Requirements**

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

225c - Additional Assessment (*continued*)

3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [REDACTED] assessment, dated [REDACTED], does not include the signature of the assessor.

Plan of Correction

Do Not Accept [REDACTED] 11/17/2025)

- *Corrective Action: The assessor has signed Resident 4's assessment.*
- *Systemic Change: A checklist for completion of assessments now includes a final verification that all sections, including signatures, are complete before filing.*
- *Person Responsible: Administrator/DON*
- *Completion Date: Corrected 11/10/2025.*

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate the specific method to audit or monitor for both current compliance and ongoing compliance.

Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

- *Corrective Action: The assessor has signed Resident 4's assessment.*
- *Systemic Change: A checklist for completion of assessments now includes a final verification that all sections, including signatures, are complete before filing.*
- *Person Responsible: Administrator/DON*
- *Completion Date: Corrected 11/10/2025.*

- *Staff is to be educated on the check list that needs to be completed before filing documents.*

- *A check list is to be completed prior to filing assessments, and a final verification is to be completed*

- *Start date 12/1/2025 and annual chart checks to be completed by the DON and the Administrator*

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] 03/30/2026)

See attached.

227g -Support Plan Signatures

43. Requirements

2600.

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

Description of Violation

Resident [REDACTED] participated in the development of [REDACTED] support plan on [REDACTED]. However, the resident did not sign the support plan.

Plan of Correction

Do Not Accept [REDACTED] - 11/17/2025)

- *Corrective Action: Resident 1 will sign the support plan.*
- *Systemic Change: The "Admission Packet Checklist" will include verification that the resident has signed the initial support plan.*
- *Person Responsible: Admissions Coordinator*
- *Completion Date: 11/10/2025.*

227g -Support Plan Signatures (continued)

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate the specific method to audit or monitor for both current compliance and ongoing compliance.

Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accepted [REDACTED] - 12/04/2025)

- *Corrective Action: Resident 1 will sign the support plan.*
- *Systemic Change: The "Admission Packet Checklist" will include verification that the resident has signed the initial support plan.*
- *Person Responsible: Admissions Coordinator*
- *Completion Date: 11/10/2025.*

- Staff will be educated on the chart audit and how to stay compliant with the support plans.

- The audit tool will be the admission checklist completed prior to move in. Will be completed by the Admissions coordinator. To start on 12/1/2025

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] 03/30/2026)

See attached.

233a - Lock Approval

44. Requirements

2600.

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

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locks, used on the exit doors from the SDCU.

Plan of Correction

Accepted [REDACTED] - 11/17/2025)

- *Corrective Action: The facility located the written approval from the Department of Labor and Industry for the magnetic locks.*
- *Systemic Change: The Administrator placed a copy in the new DHS survey readiness binder.*
- *Person Responsible: Administrator*
- *Completion Date: 11/7/2025*

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

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

233b Lock Manufacturer Statement**45. Requirements**

2600.

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the magnetic locks verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction**Accepted** [REDACTED] - 11/17/2025)

- *Corrective Action: The facility located the required statement from the lock manufacturer.*
- *Systemic Change: The Administrator placed a copy in the new DHS survey readiness binder.*
- *Person Responsible: Administrator*
- *Completion Date: 11/7/2025*

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

Evidence of Completion**Implemented** [REDACTED] - 03/30/2026)

See attached.

251b - Record Entries Legible**46. Requirements**

2600.

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

Description of Violation

Resident [REDACTED] controlled substance record for [REDACTED] is not legible on the first two lines. The original writing has been scribbled over making it illegible.

Resident [REDACTED] controlled substance records for [REDACTED] take one every 4 hours as needed has illegible entries that are written over in several spots. On line dated [REDACTED] at 17:00, the number [REDACTED] is written over [REDACTED] and on [REDACTED] at 00:40 the number [REDACTED] is written over [REDACTED]

Plan of Correction**Do Not Accept** [REDACTED] - 11/17/2025)

Corrective action The controlled substance record for resident 10 and 13 have been corrected. The DON investigated the discrepancy and provided education to staff on proper documentation

Systemic change Mandatory dual nursing count of all controlled substances at every shift change, with reporting

251b Record Entries Legible (continued)

any discrepancy to the DON and the administrator.

Person responsible DON/ administrator

Completion date investigation completed 10/20/2025 dual count policy reinforced 10/08/2025

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

Update: 11/17/2025

Please indicate any specific education to be provided for those persons responsible for ongoing compliance.

Please indicate the specific method to audit or monitor for ongoing compliance . Include specific start dates, frequencies, titles of persons responsible, etc.

Plan of Correction

Accept [REDACTED] - 12/04/2025)

Corrective action - The controlled substance record for resident 10 and 13 have been corrected. The DON investigated the discrepancy and provided education to staff on proper documentation

Systemic change- Mandatory dual nursing count of all controlled substances at every shift change, with reporting any discrepancy to the DON and the administrator.

Person responsible - DON/ administrator

Completion date - investigation completed 10/20/2025 dual count policy reinforced 10/08/2025

- The med techs and LPNs will have training to assure compliance with proper documentation of narcotics. Training will happen by 12/1/2025

- The DON will audit the narc books weekly and the med tech and nurses will continue daily narc count.

Licensee's Proposed Overall Completion Date: 12/01/2025

Evidence of Completion

Implemented [REDACTED] - 03/30/2026)

See attached.

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

March 30, 2026

[REDACTED]
MANATAWNY AL OPERATING COMPANY LLC
[REDACTED]
[REDACTED]

RE: THE RESIDENCES AT MANATAWNY
VILLAGE
30 OLD SCHUYKILL ROAD
POTTSTOWN, PA, 19465
LICENSE/COC#: 14851

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/12/2026, 01/13/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE RESIDENCES AT MANATAWNY VILLAGE

License #: 14851

License Expiration: 12/06/2025

Address: 30 OLD SCHUYKILL ROAD, POTTSTOWN, PA 19465

County: CHESTER

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: MANATAWNY AL OPERATING COMPANY LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1

Date: 06/08/2026

Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff:

Total Daily Staff: 83

Waking Staff: 62

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Monitoring

Exit Conference Date: 01/13/2026

Inspection Dates and Department Representative

01/12/2026 - On-Site: [REDACTED]

01/13/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 124

Residents Served: 52

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 24

Residents Served: 21

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 52

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 31

Have Physical Disability: 0

Inspections / Reviews

01/12/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/21/2026

02/18/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/13/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/23/2026

Inspections / Reviews (*continued*)

03/04/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/13/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/14/2026

03/30/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/13/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

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 9:45am, daily census treatment books were unlocked, unattended, and accessible at the memory care nurses station.

On [REDACTED], at 10:10am, daily census treatment books were unlocked, unattended and accessible at the memory care nurses station.

Plan of Correction

Accept [REDACTED] 03/04/2026)

* Corrective action- All daily census treatment books will be locked in the nursing station med room and not accessible.

* Systemic change - On 03/05/2026, the DON will conduct mandatory in-service training for all nursing staff (LPNs, RNs, and Med Techs) on the confidentiality requirements of 2600.17. The training will specifically address that all resident information, including census books, treatment sheets, and reports, must be kept out of view and secured in a locked area when not in direct use by staff. Attendance will be documented. Beginning 03/09/2026 and continuing indefinitely, the DON or designee will conduct daily, unannounced visual checks of the memory care nurses station and medication room during both day and evening shifts. They will verify that no confidential documents are left unlocked or unattended

* Person responsible- DON and Administrator.

Proposed Overall Completion Date: 03/10/2026

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

82c - Locking Poisonous Materials

2. 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

Sani Bleach Wipes, with a manufacture's label indicating "to contact poison control if swallowed", was unlocked, unattended, and accessible to residents in memory care. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [REDACTED] - 03/04/2026)

* Corrective action - The bleach wipes were removed right away and locked for safety.

* Systemic change -On 03/05/2026, the DON will conduct training for all clinical and housekeeping staff on the

82c Locking Poisonous Materials (continued)

proper storage of poisonous materials as per 2600.82c. Starting 03/06/2026, the Housekeeping Director and the DON will conduct weekly, unannounced audits of the Memory Care unit and all other resident areas. These audits will specifically check for any cleaning supplies, bleach wipes, or other poisonous materials that are left unlocked or unattended

** Person Responsible DON/ Housekeeping Director*

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

88a - Surfaces**3. 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 10:15a, in the chaplain/activity the ceiling was stained with a brown ring with black specs which appear to be mold.

Plan of Correction

Accept [REDACTED] - 03/04/2026)

** Corrective action The ceiling tile was replaced right away.*

** Systemic change Beginning 03/09/2026, the Maintenance Director will conduct weekly documented walk throughs of personal care, including resident rooms, common areas, and activity spaces to assess the condition of floors, walls, ceilings, windows, and doors for any damage, staining, or hazards.*

** Person responsible The Maintenance Director and Administrator*

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

96b - First Aid Location**4. Requirements**

2600.

96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff person A, did not know the location of the first aid kit.

Staff person B, did not know the location of the first aid kit.

Plan of Correction

Accept [REDACTED] - 02/18/2026)

** Corrective action Staff person A and B were reeducated on the location of the first aid kit. Staff person A also knew the location at the time of the inspection but was nervous and miss spoken.*

** Systemic change Staff to have training to make all staff be aware of where the first aid kits are on each unit. Signs are noted at each location for easy identification of the location.*

** Person responsible DON/ LPN*

Licensee's Proposed Overall Completion Date: 03/10/2026

96b - First Aid Location (continued)

Implemented [REDACTED] - 03/30/2026)

102k - No Common Towel

5. Requirements

2600.

102.k. Use of a common towel is prohibited.

Description of Violation

There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in common women's bathroom located on the 2nd floor across from the dining room.

Plan of Correction

Accept [REDACTED] - 03/04/2026)

* Corrective action - Paper towels were replaced immediately in the common woman's bathroom.

* Systemic change- Beginning 03/09/2026, the Housekeeping Director will implement a new "Restroom Supply Log." Housekeeping staff will be required to check and initial the log for each common restroom (including the 2nd floor women's bathroom) twice daily—once in the morning and once in the afternoon—to verify that soap, paper towels, and toilet paper are fully stocked. The Housekeeping Director will conduct random spot checks of at least three common bathrooms per shift, three times per week, for the first month (through 04/09/2026)

* Person responsible - Housekeeping Director/ Housekeeping Staff

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

183e - Storing Medications

6. 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 approximately 10:02am, two containers of [REDACTED] "Apply to lower gum topically 4 times daily and apply to lower gum topically as needed" were located in the medication cart for Resident [REDACTED] with no open date.

On [REDACTED], at approximately 10:05am, [REDACTED] "Place 1 drop into both eyes three times daily, was located in the medication cart for Resident [REDACTED] with no open date.

On [REDACTED] at approximately 10:06am, [REDACTED] "Insert 1 drop in both eyes three times a daily, with an expiration date of [REDACTED] remained in the medication cart for Resident [REDACTED]

Repeat violation: [REDACTED] et al and [REDACTED].

Plan of Correction

Accept [REDACTED] 03/04/2026)

* Corrective action - All 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.

* Systemic change- On 03/05/2026, the DON will conduct a mandatory in-service for all nursing staff (LPNs, Med Techs) on proper medication storage per 2600.183e. The training will cover the requirements for dating multi-use

183e - Storing Medications (continued)

containers upon opening and checking expiration dates. Effective 03/06/2026, the policy for medication cart audits will be revised. Each shift (days, evenings, nights) will be responsible for a designated cart check. Beginning 03/09/2026, the DON or a Designee will conduct a comprehensive, documented audit of all medication carts once per week

* Person responsible - Director of Nursing

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

184a - Resident's Meds Labeled**7. Requirements**

2600.

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

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

Description of Violation

A bottle of [REDACTED] tab was unlabeled in the homes personal care medication cart; however, staff present in the home could not determine who the medication belongs too.

Plan of Correction

Accept [REDACTED] - 03/04/2026)

* Corrective Action - Director of Nursing removed the unlabeled bottle of Mirtazapine immediately. All medications are to be labeled as followed:

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

* Systemic change- On 03/05/2026, the DON will conduct retraining for all nursing staff on the labeling requirements of 2600.184a. Emphasizing that a medication without a resident label is considered unidentifiable and a medication error. Effective 03/06/2026, the policy for medication cart audits will be revised. Each shift (days, evenings, nights) will be responsible for a designated cart check. Beginning 03/09/2026, the DON or a Designee will conduct a comprehensive, documented audit of all medication carts once per week

* Person responsible- Director of Nursing.

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

184b - Labeling OTC/CAM**8. Requirements**

2600.

184b Labeling OTC/CAM (continued)

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], at approximately 10:17am a bottle of [REDACTED] tablets was unlabeled in the homes personal care medication cart; however staff present in the home could not determine who the medication belongs too.

Repeat violation: [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 03/04/2026)

* *Corrective Action* Director of Nursing removed the unlabeled bottle of Tylenol immediately All medications are to be labeled as followed:

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

* *Systemic change* On 03/05/2026, the DON will conduct retraining for all nursing staff on the labeling requirements of 2600.184b for OTC medications. Staff will be trained that OTC medications, when stored for a specific resident, must be labeled with that resident's name, just like a prescription. Effective 03/06/2026, the policy for medication cart audits will be revised. Each shift (days, evenings, nights) will be responsible for a designated cart check. Beginning 03/09/2026, the DON or a Designee will conduct a comprehensive, documented audit of all medication carts once per week

* *Person responsible* Director of Nursing

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented [REDACTED] - 03/30/2026)

185a - Implement Storage Procedures**9. 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] is prescribed [REDACTED] "Take 1 tube by mouth as directed as needed.", and [REDACTED] "Insert 10 mg rectally every 24 hours as needed." and [REDACTED] "Insert 1 unit rectally every 24 hours as needed." On [REDACTED] these medication(s) were not available in the home.

On [REDACTED] at 5:47pm, the glucometer for Resident [REDACTED] documented blood sugar of [REDACTED] but it was documented as [REDACTED] on the MAR.

Repeat Violation: [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 03/04/2026)

* *Corrective action* Medications were available for administration on 1/15/2026. 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.

* *Systemic change* On 03/06/2026, the DON will conduct a training session for all nursing staff on medication

185a - Implement Storage Procedures (continued)

availability and accurate documentation. Beginning 03/09/2026, during the weekly medication cart audit, the DON/Designee will cross-reference a sample of residents' PRN orders with the medications physically present in the cart and medication room to ensure all prescribed PRNs are available.

* Person responsible - Director of Nursing

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented () - 03/30/2026)

191 - Resident Right to Refuse**11. 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's () and (), have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat violation: ()

Plan of Correction

Accept () - 03/04/2026)

* Corrective action - : On 03/05/2026, the Move-in Coordinator and DON will personally meet with Residents () and () (or their designated representatives) to provide education on their right to question or refuse a medication if they believe there may be an error. Documentation of this resident education shall be kept.

* Systemic change - On 03/09/2026, the Move-in Coordinator will be trained on ensuring that during the admission conference, this specific right is reviewed with every new resident and their family, and the documentation is signed and dated. Beginning 03/09/2026, and continuing monthly thereafter, the Administrator or designee will audit the admission records of all new residents from the previous month. The audit will verify that the "Right to Refuse Medication" education is documented and signed

* Person responsible - Move in director and Administrator.

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented () - 03/30/2026)