

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

June 3, 2025

[REDACTED], DIRECTOR OF CONTINUING CARE
ANNS CHOICE INC
16000 ANN'S CHOICE WAY
WARMINSTER, PA, 18974

RE: ANN'S CHOICE
16000 ANN'S CHOICE WAY
WARMINSTER, PA, 18974
LICENSE/COC#: 12901

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/03/2025, 02/04/2025 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: ANN'S CHOICE License #: 12901 License Expiration: 07/22/2025
 Address: 16000 ANN'S CHOICE WAY, WARMINSTER, PA 18974
 County: BUCKS Region: SOUTHEAST

Administrator

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

Legal Entity

Name: ANNS CHOICE INC
 Address: 16000 ANN'S CHOICE WAY, WARMINSTER, PA, 18974
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 11/19/2018 Issued By: Warminster Township L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 112 Waking Staff: 84

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Incident Exit Conference Date: 02/04/2025

Inspection Dates and Department Representative

02/03/2025 - On-Site: [REDACTED]
 02/04/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 65 Residents Served: 61

Secured Dementia Care Unit

In Home: Yes Area: Garden View Court Capacity: 44 Residents Served: 40

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 61
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 51 Have Physical Disability: 0

Inspections / Reviews

02/03/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/17/2025

03/20/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/02/2025
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 05/02/2025

Inspections / Reviews *(continued)*

06/03/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/02/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 2/3/2024 at 9:23 am, an agent of the Department, requested access to staff list to include date of hire and job title from staff person A. At 12:52 pm, staff person A provided staff list without hire dates for the ancillary staff. At approximately 1:00 pm, staff person A provided the complete staff list.

Plan of Correction

Accept ([redacted] - 03/19/2025)

- Current direct care staff and ancillary staff list was updated immediately.
- Beginning with the week of 3/17/25, direct care staff and ancillary staff lists will be updated weekly by the department managers.
- PC Administrator or designee will audit the staff lists weekly x 6 weeks to ensure hire dates are included.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented ([redacted] - 06/03/2025)

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 1/11/2025, staff B returned to the home following the home's internal investigation. The home did not develop and implement a plan of supervision approved by the Department.

Plan of Correction

Accept ([redacted] - 03/19/2025)

- A plan of supervision was developed and submitted to DHS for approval on 2/5/25.
 - The approved Plan of Supervision was implemented upon the Employee's return to work date from [redacted] on 2/21/2025.
 - Plan of Supervision was also distributed to Memory Care Wellness Manager, Memory Care Manager and PC Administrator on 2/21/2025.
 - All future alleged perpetrators identified in Allegations of abuse in the Personal Care neighborhoods will not return to work until DHS approval has been received for Plan of Supervision.
- Audits of future Allegation of Abuse investigations will be completed by the PC Administrator to confirm DHS approval has been received and is part of investigation file prior setting the employees return to work.
- Audits will be reviewed at QAPI meeting x 2 beginning April 2025.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented ([redacted] - 06/03/2025)

15b - Supervisor Plan (continued)

18 - Compliance With Laws

3. Requirements

2600.

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

Description of Violation

On 2/3/25, an influenza awareness poster was not present in the first-floor personal care area.

Plan of Correction

Accept (█ - 03/19/2025)

- Influenza awareness poster was immediately posted in the first floor personal care neighborhood.
- The PC Administrator will review the DHS PCH Provider Resources monthly for required postings related to applicable health and safety laws.
- Beginning with the week of 3/17/25, all personal care neighborhoods will be audited weekly x 6 weeks by PC Administrator or designee to ensure required posters have been posted.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█ - 06/03/2025)

25b - Contract Signatures

4. 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 #1 was not signed by the resident and there is no notation on why the resident was unable to sign.

The resident-home contract, dated █, for resident #2 was not signed by the resident and there is no notation on why the resident was unable to sign.

The resident-home contract, dated █, for resident #3 was not signed by the resident and there is no notation on why the resident was unable to sign.

The resident-home contract, dated █, for resident #4 was not signed by the resident and there is no notation on why the resident was unable to sign.

The resident-home contract, dated █, for resident #5 was not signed by the resident and there is no notation on why the resident was unable to sign.

25b - Contract Signatures (continued)

Plan of Correction

Accept (█) - 03/19/2025)

- The resident-home contracts for residents #1, 2, 3, 4, 5 were signed by the resident or a notation on why the resident was unable to sign was documented by 3/14/25.
- The PC administrator or designee will audit all PC resident-home contracts to ensure resident has signed the contract or if unable to sign, that efforts made to obtain signature are documented. Audit to be completed by 3/21/25.
- Admissions Coordinator or designee will obtain resident signature on all new resident-home contracts or will document the efforts made to obtain signature.
- Beginning with the week of 3/17/25, all new personal care admission contracts will be audited weekly x 6 weeks by PC Administrator or designee to ensure contracts include appropriate signatures or documentation of efforts made to obtain signatures.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█) - 06/03/2025)

28e - Death of a Resident

5. 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.

Description of Violation

Resident #6 passed away on █. However, the home did not issue a refund until █

Repeated Violation: 4/9/2024

Plan of Correction

Accept (█) - 03/19/2025)

- Refund for Resident #6 who passed away on █ was disbursed on █.
- Business Office Manager or █ designee will audit the accounts for residents who have passed away or discharged between 1/1/25 and 2/28/25 to confirm the home provided a refund in accordance with the Elder Care Payment Restitution Act. Audit will be completed by 3/21/25 . Payments for any outstanding balances that are not within compliance will be paid by 3/31/2025.
- Business Office Manager or █ designee, will continue to audit the accounts of residents who have passed away or discharged through 4/30/25 to confirm compliance.
- Results of audits will be presented at QAPI x 2 months beginning in April.

28e - Death of a Resident (continued)

Licensee's Proposed Overall Completion Date: May 2, 2025

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█) - 06/03/2025)

41e - Signed Statement**6. 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

Residents #1, #2, #3, #4, and #5 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

Accept (█) - 03/19/2025)

- Admissions Coordinator or designee will review Residents Rights with Resident #1, #2, #3, #4 and #5 and a signed copy will be filed in the resident's record by 3/21/25.
- The PC Administrator or designee will audit all PC resident records to ensure a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures or documentation of efforts made to obtain the residents signature are included with each resident contract. Audits to be completed by 3/21/25.
- Admissions Coordinator or designee will complete review of Resident Rights with all new admissions and a signed copy will be filed in the resident's record.
- Beginning with the week of 3/17/25, audits of all new personal care admission contracts will be completed weekly x 6 weeks by PC Administrator or designee to ensure contracts include resident rights and the appropriate signatures or documentation of efforts made to obtain signatures.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█) - 06/03/2025)

42c - Treatment of Residents**7. Requirements**

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 1/2/2025, resident #1 reported that staff person B was "nasty", "rude" and █ did not feel safe. During staff interviews on 2/4/2025, staff person B admitted to writing a note in a communication book that is accessible to other staff members referring to Resident #1 feet as "nasty."

42c - Treatment of Residents (continued)

Plan of Correction

Accept () - 03/19/2025

- Staff person B was educated on Resident Rights on 2/21/25.
- Staff educator or designee will educate PC staff on Resident Rights including treating residents with dignity and respect annually.
- Staff educator or designee will audit to ensure 90% of PC staff have received education on Resident Rights by 4/30/25.
- Results of audits will be presented at May QAPI meeting.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented () - 06/03/2025

65g - Annual Training Content

8. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in Resident Rights and The Older Adult Protective Services Act during training year 2024.

Repeated Violation: 4/9/2024

Plan of Correction

Accept () - 03/19/2025

- Education of Staff Person B will be completed with Supervisor on next scheduled workday, 3/24/25, prior to start of shift.
- Staff educator or designee will educate PC staff on "Resident Rights" and "The Older Adult Protective Services Act" annually.
- Staff educator or designee will audit PC staff training records to ensure 90% of PC staff have received education on "Resident Rights" and "The Older Adult Protective Services Act" by 4/30/25.
- Results of audits will be presented at May QAPI meeting.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented () - 06/03/2025

103d - Storing Food Off Floor

9. Requirements

103d - Storing Food Off Floor (continued)

2600.

103.d. Food shall be stored off the floor.

Description of Violation

On 2/3/25, at approximately 10:21 am, three 5-gallon water bottles were stored on the floor in the basement.

Plan of Correction

Accept () - 03/20/2025

- The 5 gallon water bottles were immediately moved and stored off the floor.
- Beginning with the week of 3/17/25, PC Administrator or designee will audit weekly x 6 weeks to ensure water bottles are stored off the floor.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented () - 06/03/2025

105f - Labeling/Return of Clothes

10. Requirements

2600.

105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

The home does not have a system to safeguard resident laundry from loss.

Plan of Correction

Accept () - 03/20/2025

- All residents clothing will be removed from room and washed individually by CAMS. Laundry will then be dried, folded and returned to resident's room. When an item is missing, it should be reported to CAM/Supervisor/Manager and a Missing Item Form Completed.
- For newly reported missing items, PC Administrator or MC Manager will conduct a missing items investigation according to policy and document results on the Missing Item Form.
- Follow-up will be provided to resident and/or family member to notify them if Item was able to be found according to policy.
- Beginning with the week of 3/17/25, PC Administrator or designee will complete audits of Missing Item Forms weekly x 6 weeks to ensure Missing Item Investigations are completed according to policy.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented () - 06/03/2025

121a - Unobstructed Egress

11. Requirements

2600.

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

121a - Unobstructed Egress (continued)

Description of Violation

On 2/3/2024, at approximately 9:30 am, the emergency exits 1, 2, 3, and 4 did not open when the push bar was pushed. Instead, it only unlocked when a code was entered on the keypad. However, since the codes were not posted, this created a blocked egress.

Plan of Correction

Accept () - 03/20/2025

- Codes were immediately posted to Emergency exits 1, 2, 3 and 4.
- Beginning with the week of 3/17/25, PC Administrator or designee will audit weekly x 6 weeks to ensure codes are posted at Emergency exits 1, 2, 3 and 4.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented () - 06/03/2025

132c - Fire Drill Records

12. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted on 5/14/2024, 6/25/2024, 7/25/2024, 8/4/2024, 9/15/2024, 10/27/2024, 11/19/2024, 12/13/2024, and 1/17/2025 does not include all residents and all staff members who participated during the drill. Per staff person A, the documentation provided is only for the floor that is being monitored during the fire drill.

Plan of Correction

Accept () - 03/20/2025

- Maintenance Supervisor will request from () Fire Safety Corporation staff that when conducting fire drills for Personal Care areas, including Memory Care, the documentation of all residents and all staff members who participated during the drill be included in the fire drill documentation.
- Beginning with April's Fire Drills, documentation will be audited x 2 months to verify all residents and all staff members who participated during the drill be included in the fire drill documentation.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented () - 06/03/2025

171b5 - First Aid Kit

13. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in vehicle number 108 used to transport residents does not include breathing shield or eye coverings.

Plan of Correction

Accept (█) - 03/20/2025)

- *Breathing shield and eye coverings will be provided to the first aid kit in vehicle number 108 on 3/17/25.*
- *Assistant Administrator provided education to the Transportation Manager, 2/5/2025, regarding required contents of first aid kits.*
- *Transportation Manager will audit the First aid kits in the vehicle fleet monthly x 2 months to ensure they include breathing shields and eye coverings.*
- *Results of audits will be presented at QAPI x 2 months beginning in April.*

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█) - 06/03/2025)

185a - Implement Storage Procedures**14. 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 2/1/25, at approximately 4:18 am, resident #2's glucometer displayed 106. However, it was documented as 144 on the Medication Administration Record.

On 2/2/25, at approximately 8:12 am, resident #2's glucometer displayed 92. However, it was documented as 94 on the Medication Administration Record.

On 2/2/25, at approximately 10:20 am, resident #2's glucometer displayed 255. However, it was not documented on the Medication Administration Record.

On 2/4/25, at approximately 8:35 am, resident #2's glucometer displayed 214. However, it was not documented on the Medication Administration Record.

On 2/1/25, at approximately 11:49 am, resident #7's glucometer displayed 126. However, it was documented as 127 on the Medication Administration Record.

On 2/4/25, at approximately 10:40 am, resident's #7's glucometer was not calibrated to the correct date and time. The glucometer was reading 8/2/24 at 12:13 pm.

Repeated Violation: 4/9/2024

185a - Implement Storage Procedures (*continued*)**Plan of Correction**

Accept (█ - 03/20/2025)

- Staff Development Coordinator or designee will educate PC nurses on calibrating, reading and documentation of the glucometer.
- Wellness Manager or designee will complete a random weekly audit x 6 weeks of 10% of all PC residents with an order for an insulin to ensure pens are properly calibrated.
- Beginning with the week of 3/17/25, Wellness Manager or designee will complete a random weekly audit x 6 weeks of 10% of all PC residents with an order for an insulin to ensure the reading on the glucometer matches the documentation in the MAR.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█ - 06/03/2025)

187d - Follow Prescriber's Orders

15. Requirements

2600.

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

Description of Violation

Resident #8 is prescribed Balmex Adult Care 11.3% topical cream, apply two times daily to buttocks. However, on 2/4/25, this medication was not available in the home.

Plan of Correction

Accept (█ - 03/20/2025)

- 2/4/25 Balmex Adult Care 11.3% topical cream was re-ordered for resident #8.
- Staff Development Coordinator or designee will provide education on proper ordering of medications to PC staff who are responsible for ordering medications by 3/31/25.
- Beginning with week of 3/17/25, Wellness Manager or designee will complete a random weekly audit x 6 weeks of 10% of PC resident's medications to ensure medication is available.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█ - 06/03/2025)

191 - Resident Right to Refuse

16. 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 #1 admitted █ has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #2 admitted on █ has not been educated to the resident's right to refuse medication if the

191 - Resident Right to Refuse (continued)

resident believes that there may be a medication error.

Resident #3 admitted on [REDACTED], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #4 admitted on [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #5 admitted on [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept ([REDACTED] - 03/20/2025)

- Admissions Coordinator or designee will review Residents Rights including the right to question or refuse a medication with Resident #1, #2, #3, #4 and #5 and a signed copy will be filed in the resident's record by 3/21/25.
 - Beginning with the week of 3/17/25, the PC Administrator or designee will audit all PC resident records to ensure a statement signed by the resident acknowledging receipt of a copy of the resident rights, including their right to refuse medication, is included in their contract; if resident was unable to sign, documentation of efforts made to obtain the residents signature are included.
 - Admissions Coordinator or designee will complete review of Resident Rights, including the right to question or refuse a medication, with all new admissions and a signed copy will be filed in the resident's record.
- Beginning week of 3/17/25, Audits of all new Personal Care admission contracts will be completed weekly x 6 weeks by PC administrator or designee to ensure contracts include resident rights and the appropriate signatures or documentation of efforts made to obtain signatures.
- Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented ([REDACTED] - 06/03/2025)

227g -Support Plan Signatures**17. 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 #1 participated in the development of [REDACTED] support plan on [REDACTED]. However, the resident did not sign the support plan.

Resident #2 participated in the development of [REDACTED] support plan on [REDACTED]. However, the resident did not sign the support plan.

Resident #9 participated in the development of [REDACTED] support plan on [REDACTED]. However, the resident did not sign the support plan.

227g -Support Plan Signatures (continued)*Repeated Violation: 4/9/2024***Plan of Correction****Accept (█ - 03/20/2025)**

• Support plan signatures will be obtained for Residents # 1, 2, and 9 or efforts to obtain signatures will be documented by 3/21/25.

-PC Administrator or designee, will educate the PC Managers on the requirement to obtain the resident's signatures on the Support Plans. Education to be completed by 3/21/25

The PC Administrator or designee will audit all support plans to ensure they include a signature from the resident or documentation of efforts made to obtain the residents' signature by 3/21/25.

• Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█ - 06/03/2025)**231c - Preadmission Screening****18. Requirements**

2600.

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

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on █ However, the resident's written cognitive preadmission screening was completed on █

*Repeated Violation: 4/9/2024***Plan of Correction****Accept (█ - 03/20/2025)**

• All new Memory Care admissions to the Secure Dementia Neighborhood will have the Preadmission Screening completed by a physician or a geriatric assessment team member and documented on the Department's preadmission screening form within 72 hours prior to admission.

• Geriatric assessment team members will be educated by the Staff Development Coordinator or designee on the requirement to complete the Preadmission Screening form within 72 hours prior to admission.

• All Cognitive Pre-Screens for new MC residents will be audited weekly by PC Administrator or designee for 6 weeks to ensure they were completed within 72 hours of admission.

• Results of audits will be presented at QAPI x 2 months beginning in April.

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█ - 06/03/2025)**233c - Key-Locking Devices****19. Requirements**

2600.

233c - Key-Locking Devices (continued)

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 2/3/2025, the directions for operating the home's locking mechanism were not conspicuously posted near the door to the Secure Dementia Care Unit. Instructions were not posted next to the keypad devices in Stairs 1, 3, and 4 in the memory care unit, as well as at the main door near Stair 4 leading to the memory care unit.

Plan of Correction**Accept (█ - 03/20/2025)**

- Instructions were immediately posted near the door to the Secure Dementia Care Unit and near the keypad devices in Stairs 1, 3, and 4.*
- Beginning with the week of 3/17/25, PC Administrator or designee will audit weekly x 6 weeks to ensure instructions are posted near the door to the Secure Dementia Care Unit and near the keypad devices in Stairs 1, 3, and 4.*
- Results of audits will be presented at QAPI x 2 months beginning in April.*

Licensee's Proposed Overall Completion Date: 05/02/2025

Implemented (█ - 06/03/2025)