pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **INSPIRIT MACUNGIE OPERATOR LLC**
LEGAL ENTITY

To operate **THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY**
NAME OF FACILITY OR AGENCY

Located at **6488 ALBURTIS ROAD, MACUNGIE, PA 18062**
(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 **67**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **June 6, 2025** until **December 6, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226811**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 11, 2025

[redacted]
Interim Administrator
Inspirit Macungie Operator LLC
6488 Alburtis Rd
Macungie, Pennsylvania 18062

RE: The Willow, An Inspirit Senior Living Community
License # 226811

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 12, 2025, April 16, 2025, April 21, 2025, and April 28, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 226810) dated November 7, 2024 to November 7, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated November 7, 2024 to November 7, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from June 6, 2025 to November 6, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with Choose an item., must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of	Census at	Fine Per resident	Calculated Fine	Mandated Correction Date

or 2800 Section:	Violation	Inspection	X Per day	= Per day	(to avoid Fine)
185a	II	44	$5	$220	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
[redacted]

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY* **License #**: *22681* **License Expiration**: *11/07/2025*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *INSPIRIT MACUNGIE OPERATOR LLC*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA, 18062*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/09/2002* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *42* **Waking Staff**: *32*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/12/2025*

Inspection Dates and Department Representative

02/12/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *38*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*

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

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

02/12/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/16/2025*

03/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/28/2025*

04/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/30/2025*

05/22/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The licensing inspection summaries dated 10/24/24 and 3/7/24 were not posted in a public conspicuous place in the home.

Plan of Correction ***Accept (- 03/21/2025)***

The missing inspection summaries were posted at time of inspection and shown to inspector its completion.
To ensure compliance of this regulation, the Executive Director will conduct monthly safety audits (see attached) starting 3/20/25 and will continue for 6 months. The audit binder will be maintained in the Executive Directors Office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

17 - Record Confidentiality

2. 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

The licensing inspection summary dated 1/18/23 posted on the bulletin board near the bathroom on the 1st floor had the privacy coding document attached. The privacy coding document has residents names on it and exposes confidential information of the residents.

Plan of Correction ***Accept (- 03/21/2025)***

The privacy coding that was mistakenly posted with the LIS was removed at time of inspection and shown to inspector upon its completion.
To ensure compliance of this regulation, the Executive Director will conduct monthly safety audits (see attached) starting 3/20/25 and will continue for 6 months. The audit binder will be maintained in the Executive Directors Office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented (- 05/20/2025)

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

The batteries in the carbon monoxide detectors located throughout the home either had no date on them or they were last changed 4/28/23. As per The Care Facilities Carbon Monoxide Alarm Standards Act the batteries must be changed annually.

Repeat Violation: 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

All CO2 detector batteries were changed and dated on the day of the inspection by the Director of Maintenance
Going forward, the Director of Maintenance will do monthly battery checks and log completion in the TELs systems. First check to be completed by March 31st.
Logs of completion will be kept in the Audit binder, which will be maintained in the Executive Directors office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

25a - Written Contract and Review

4. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident # 5 had multiple respite stays in the home from 3-13-24 to 3-19-24, 5-27-24 to 6-2-24, 8-2-24 to 8-7-24, 8-14-24 to 8-19-24,10-9-24 to 10-16-24 and from 12-11-24 to 12-18-24. A resident contract was not completed by the home.

Plan of Correction ***Accept (- 03/21/2025)***

At that time of admissions, staff had completed a respite addendum instead of a full contract, this resident had already been discharged from respite stay at the time of the inspection.
Going forward, effective immediately, the Community Relations Director will ensure that all Residents who reside in our community under a Respite stay, will complete a full Residency Agreement.
To ensure compliance, every new resident will have the attached checklist completed, effective immediately. Also, the Executive Director will conduct resident file audits (see attached) beginning 3/24/2025 every month for 6 months. The audit binder will be maintained in the Executive Directors office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

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

Not Implemented (- 05/20/2025)

51 - Criminal Background Check

5. 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 member A's 1st day of work was . The staff member's Pennsylvania State Police Criminal Background Check was not requested by the home until

Staff member B's 1st day of work was . The staff member's Pennsylvania State Police Criminal Background Check was not requested by the home until

Plan of Correction ***Accept (- 03/21/2025)***

On 2/18/2025 staff, in particular the Business Office Manager who conducts background checks on new employees was trained on OAPSA, see attached sign in sheet and meeting agenda.
To ensure compliance of this regulation, effective immediately, the BOM will utilize a new hire checklist has been implemented and reflects the timeframe in which a background check must be completed for a new employee. This checklist will be maintained by the business office manager in the employee's file.
Starting on 3/17/2025, the Executive Director will conduct Employee file audits every month for 6 months. The audit binder will be maintained in the Executive Directors Office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
3. Care for residents with dementia and cognitive impairments.

Description of Violation

Direct care staff Member C did not complete annual training on care for residents with dementia and cognitive impairments or medication self-administration during training year 2024.

Repeat Violation: 1-3-24

65f - Training Topics (continued)

Plan of Correction ***Accept ([redacted] - 04/01/2025)***

Immediate actions taken:

Staff member C was given supplementary training by the regional operations specialist on those topics, see attached signed acknowledgement.

A one-time audit will be conducted by the regional operations specialist on 3/31/25 to review the 2024 annual training binder to ensure no other staff persons missed any required training, and if they did, will receive additional supplemental training as well.

Ongoing compliance and monitoring:

Effective immediately, the Business Office Manager will review the annual all staff training binder after each monthly all-staff meeting and will note which staff persons did not attend. All staff persons who did not attend will receive a "make up packet" of the presentation to review and sign off.

To monitor this plan of correction and ensure compliance, starting on 3/17/2025, the Executive Director will conduct Employee file audits every month for a minimum of 6 months. The audit binder will be maintained in the Executive Directors Office.

Compliance will be monitored by the leadership team through the quality management meeting where the training plan and audits will be reviewed. The next meeting is scheduled 4/1/2025 (see attached agenda)

Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented ([redacted] - 05/20/2025)

65g - Annual Training Content

7. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
5. Falls and accident prevention.

Description of Violation

Direct care staff Member C did not complete annual training on falls and accident prevention during training year 2024.

Repeat Violation: 1-3-24

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept (- 04/01/2025)***

Immediate actions taken:
Staff member C was given supplementary training by the regional operations specialist on those topics, see attached signed acknowledgement.
A one-time audit will be conducted by the regional operations specialist on 3/31/25 to review the 2024 annual training binder to ensure no other staff persons missed any required training, and if they did, will receive additional supplemental training as well.
Ongoing compliance and monitoring:
Effective immediately, the Business Office Manager will review the annual all staff training binder after each monthly all-staff meeting and will note which staff persons did not attend. All staff persons who did not attend will receive a "make up packet" of the presentation to review and sign off.
To monitor this plan of correction and ensure compliance, starting on 3/17/2025, the Executive Director will conduct Employee file audits every month for a minimum of 6 months. The audit binder will be maintained in the Executive Directors Office.
Compliance will be monitored by the leadership team through the quality management meeting where the training plan and audits will be reviewed. The next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

81b - Resident Personal Equipment

8. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

The resident in room 107 utilizes an enabler bar. The enabler bar has an opening 18" long by 12" high. The opening was uncovered. This opening would allow for enough room to become entrapped and cause possible harm or death.

Repeat Violation: 1-3-24

Plan of Correction ***Accept (- 04/01/2025)***

Immediate Actions:
Resident enabler was replaced with a Halo Ring on 3/13/2025 by physical therapist, see attached picture.
On 3/13/2025 the Resident Care Coordinator, Resident Wellness Director, Maintenance Director and others were educated by the Regional Operations Specialist, on the guidance from the Department of Human Services on Use of Bedside Mobility Devices in PCH's as well as Inspirit Senior Livings policy on use of bed rails. See Attached
On 3/19/2025 a full apartment audit was conducted by the Regional Operations Specialist to review any other residents who have enablers, please see attached audit.
Executive Director will maintain the tracking/audit sheet going forward to ensure knowledge of the use of all bed enablers within the community and this enabler tracking/audit will be maintained in the Executive Directors office.
For ongoing compliance, Review/training on Inspirit Senior Livings policy on use of bed rails and enforcement of

81b - Resident Personal Equipment (continued)

this regulation will be reviewed with the physical therapist as well by the Regional Operations specialist on 3/31/25.
For long term monitoring of this regulation, beginning 3/20/2025, the Executive Director will conduct safety audits which includes checking resident rooms that have enablers to ensure they are attached securely and meet size requirements, on a monthly basis for a minimum of 6 months. The audit binder will be maintained in the Executive Directors office
Sustainable long-term plan to maintain compliance to prevent re-occurrence, the leadership team will review safety audit findings as a standing agenda item on the quality management meetings. Non-compliance noted in any safety audits will be addressed immediately with retraining or corrective actions by the Executive Director. Next QMP meeting is scheduled 4/1/2025

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented ([redacted] - 05/20/2025)

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At approximately 10:30 a.m., the 3rd floor kitchenette's bottom cabinet located below the coffee maker, had a blanket that was stained brown and the cabinet floor was stained brown, black and white. Interviews with staff indicated that the coffee maker would overflow into this cabinet.

At approximately 10:00 a.m. the bottom of the inside of the freezer in the 2nd floor activity room had a brown sticky substance that was over 50 percent of it.

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

Both areas were cleaned at the time of inspection, see attached picture
Staff were educated on 2/18/2025 of this regulation and compliance of by the interim Executive Director, see attached meeting minutes
Beginning 3/20/2025, the Executive Director will conduct safety audits on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented ([redacted] - 05/20/2025)

88a - Surfaces

10. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

88a - Surfaces *(continued)*

Description of Violation

At approximately 10 a.m., the 2nd floor activity room, had an extension cord that stretched across the floor connecting to a piano lamp.

Plan of Correction ***Accept (- 03/21/2025)***

Extension cord was removed at time of inspection, see attached picture
Staff were educated on 2/18/2025 of this regulation and compliance of by the interim Executive Director, see attached meeting minutes
Beginning 3/20/2025, the Executive Director will conduct safety audits on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The bathroom sink in resident room 107 had a water temperature of 127.5 degrees Fahrenheit.

The bathroom sink in resident Room 114 had a water temperature of 129 degrees Fahrenheit.

Repeat Violation: 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

Maximum hot water heater temp was turned down at the time of the inspection to ensure compliance of this regulation.
On 2/18/25, 2/27/25, 3/5/25, 3/11/25, random water checks were completed by the Director of Maintenance, see attached log sheet.
Beginning 3/20/2025, the Executive Director will conduct safety audits which will include random room water temp checks, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

93b - Railings

12. Requirements

93b - Railings *(continued)*

2600.
93.b. Each porch must have a well-secured railing.

Description of Violation

At approximately 10 a.m., the 2nd floor balcony exiting from the activity room, had a 16 foot section of railing that was loose and moved from side to side when grabbed.

Plan of Correction ***Accept (- 03/21/2025)***

At the time of inspection, the door to the balcony was locked indefinitely until the railing was repaired.
Maintenance Director has begun placing brackets to secure the railing, project to be completed by 3/21/25
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

[redacted]

Withdrawn 5/29/25

[redacted]

103d - Storing Food Off Floor

14. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At approximately 10:35 a.m. a box of potato chips was noted on the floor of the food storage area near the back of

103d - Storing Food Off Floor (continued)

the kitchen.

Plan of Correction ***Accept (- 03/21/2025)***

Box of chips was placed on a shelf at the time of inspection as well as signage in the storage areas. See attached
On 3/18/2025 a staff meeting is scheduled, and staff will be re-educated by the Director of Dining Services on food storage procedures. See attached agenda
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

103e - Left Overs

15. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 10:15 a.m. the walk-in freezer in the kitchen had a pie without a label or date,

At approximately 10:00 a.m. a meat and cheese tray were noted in the refrigerator in the 2nd floor activity room without a label or date.

At approximately 10:15 a.m. a 22-quart container of what was identified as breadcrumbs did not have a label or date on it. The container was located under the metal table in the kitchen.

At approximately 10:20 a.m. a container of yellow food, brown food identified as brownies and chicken noodle soup were noted in the walk-in refrigerator in the kitchen without a label or date.

Plan of Correction ***Accept (- 03/21/2025)***

On day of inspection, all food was disposed of that was not covered, labeled, or dated. Signage was posted to remind staff to cover, label and date all food.
On 2/18/25 staff were educated of this regulation by the Interim Executive Director. Please see attached meeting minutes
On 3/18/2025 a staff meeting is scheduled, and staff will be re-educated by the Director of Dining Services on food storage procedures. See attached agenda
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

103e - Left Overs *(continued)*

Implemented ([redacted] - 05/20/2025)

103f - Refrigerator/Freezer Temps

16. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At approximately 10:00 a.m. the freezer in the 2nd floor activity room did not contain a thermometer.

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

On day of inspection a thermometer was placed in the activity freezer.
On 2/18/2025 staff were educated on this regulation by the Interim Executive Director, see attached meeting minutes
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented ([redacted] - 05/20/2025)

103g - Storing Food

17. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 10:15 a.m. the lids to the 22-quart containers of sugar, flour and what was identified as breadcrumbs were ajar. The containers were located under the metal table in the kitchen.

At approximately 10:20 a.m. a tray of mandarin oranges, a pound of butter and chicken marinating in a white sauce were in the walk-in refrigerator in the kitchen without a cover/seal.

Repeat Violation: 1-17-24

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

On day of inspection, all food was disposed of that was not covered, labeled, or dated. Signage was posted to remind staff to cover, label and date all food.
On 3/18/2025 a staff meeting is scheduled, and staff will be re-educated by the Director of Dining Services on food storage procedures. See attached agenda
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit

103g - Storing Food (continued)

binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

103i - Outdated Food

18. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At approximately 10:15 a.m. an 80oz. can of grated parmesan cheese with an expiration date of 9/4/24 was noted in the refrigerator next to the stove in the kitchen.

Repeat Violation: 1-17-24

Plan of Correction ***Accept (- 03/21/2025)***

On day of inspection, all food was disposed of that was outdated.
On 3/18/2025 a staff meeting is scheduled, and staff will be re-educated by the Director of Dining Services on food storage procedures. See attached agenda
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

105g - Lint Removal and Duct Cleaning

19. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At approximately 9:45 a.m. the 2nd floor laundry room had a large accumulation of lint scattered behind the dryer. At approximately 10:30 a.m. in the 3rd floor laundry room, lint and paper were observed behind the dryers and right next to the exhaust vent.

Repeat Violation: 1-3-24

105g - Lint Removal and Duct Cleaning (continued)

Plan of Correction ***Accept (- 03/21/2025)***

Room was cleaned by housekeeping staff at time of inspection. Signage was hung as a reminder to keep area clean and lint free.
On 2/18/25 staff were educated on this regulation by the Interim Executive Director, see attached meeting minutes
On 3/18/2025 a staff meeting is scheduled, and staff will be re-educated on the importance of keeping the laundry room clean and lint free by the Director of Maintenance. See attached agenda
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

132a - Monthly Fire Drill

20. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An interview with ancillary staff member F indicated that the 2nd and 3rd shift staff have been made aware of the fire drills in advance. The staff member reported that will do a training with them and let them know there will be a drill prior to it being conducted.

Plan of Correction ***Accept (- 03/21/2025)***

Director of Maintenance who is responsible of coordinating fire drills has been re-educated of this regulation by the Regional Operations Specialist on 3/14/2025. See attached record of training
Beginning 3/20/2025, the Executive Director will conduct safety audits to include monitoring of fire drills, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

132b - Safety Inspection/Fire Drill

21. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The letter from the fire safety inspector dated 3-19-24 notes in the 2nd floor housekeeping room there are outlet multipliers plugged into a power strip. This fire hazard has not been corrected.

132b - Safety Inspection/Fire Drill (continued)

Repeat Violation: 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

Hazard was removed at time of inspection. See attached picture.
On 2/18/25 a staff meeting was held and staff were re-educated on fire hazards by the Interim Executive Director, see attached agenda
Fire safety inspection is scheduled on 3/21/25 with Fire Life and Safety Solutions as well.
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

[redacted]

Withdrawn 5/29/25

[redacted]

[redacted]

132h - Designated Meeting Place

23. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Two residents refused to evacuate during the fire drill conducted on 7/29/24 at 6:00 a.m. One resident refused to evacuate during the fire drill conducted on 8/10/24 at 3:46 p.m.

An interview with Ancillary staff member F indicated that the residents located on the first floor will evacuate to the front glass doors in the lobby. This area is not a fire safe area when the fire is on the first floor of the home, the residents need to evacuate to the outside of the building.

132h - Designated Meeting Place (continued)

Plan of Correction ***Accept (- 03/21/2025)***

Director of Maintenance who is responsible of coordinating fire drills has been re-educated of this regulation by the Regional Operations Specialist on 3/14/2025. See attached record of training
Staff meeting is scheduled 3/18/2025 and fire drill procedures will be reviewed with staff by the Director of Maintenance, see attached agenda
To ensure compliance of this regulation, an observed fired drill and annual inspection is scheduled on 3/21/2025 with the fire safety expert.
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

[redacted]

Description of Violation

[redacted]

162c - Menus Posted

25. Requirements

2600.

162c - Menus Posted *(continued)*

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

Description of Violation

The menu required to be posted one week in advance was not available.

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

Menu was posted at the time of inspection and Culinary Director was re-educated of this regulation by the Interim Executive Director.
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented ([redacted] - 05/20/2025)

171b4 - Staff Training

26. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

Description of Violation

The homes driver, staff member D has not completed the direct care staff person training. Through interviews with the home, it was confirmed that the staff member has transported residents alone to appointments.

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

Staff member D completed the direct caregiver training on 2/18/2025, see attached
To ensure compliance of this regulation, effective immediately the business office manager will institute a new hire checklist that notes who needs to obtain a direct caregiver certification prior to first day of work, see attached.
Starting on 3/17/2025, the Executive Director will conduct Employee file audits every month for 6 months. The audit binder will be maintained in the Executive Directors Office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented ([redacted] - 05/20/2025)

181d -Storing Medication

27. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

181d -Storing Medication *(continued)*

Description of Violation

Resident in room 114 self-administers medications. The room was found unlocked and accessible with all the medications in the bathroom unlocked.

Plan of Correction ***Accept (- 03/21/2025)***

Resident was re-educated on the importance of locking medications by the Resident Wellness Director. did opt to using a lock box to store medications which was purchased for on 3/10/25.
Beginning 3/20/2025, the Executive Director will conduct safety audits to ensure medications are locked, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

183b - Meds and Syringes Locked

28. Requirements

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

Description of Violation

At approximately 12:19 p.m. the medication cart located on the 3rd floor outside of the dining area was unlocked and unattended.

Repeat Violation 3-7-24 et al

Plan of Correction ***Accept (- 03/21/2025)***

The medication cart was locked immediately upon discovery and staff were educated on this regulation by the Interim Executive Director on 2/18/2025 see attached meeting minutes.
Another Staff meeting is scheduled 3/18/2025 and staff will be re-educated by the Resident Wellness Director on Medication Storage, see attached agenda
Beginning 3/20/2025, the Executive Director will conduct safety audits, on a monthly basis for 6 months. The audit binder will be maintained in the Executive Directors office
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/22/2025)

183d - Prescription Current

29. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current *(continued)*

Description of Violation

Resident # 6's albuterol sol 2.5gm/3ml was discontinued on 1/27/25. The medication was noted in the medication cart at the time of the inspection.

Plan of Correction ***Accept (- 03/21/2025)***

Medication was disposed of immediately at the time of inspection.
Cart audit was completed by pharmacy on 3/11/25
Staff will be re-educated on medication procedures by the resident wellness director on 3/18/2025 see attached agenda
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication cart audits starting on 3/25/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

183e - Storing Medications

30. 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

Resident #8's Albuterol HFA 90MCG inhaler expired on 12/31/24, and was still present in the medication cart available for resident use.

Repeat Violation: 3-7-24 et al, 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

Expired medication was disposed of at the time of inspection. Pharmacy delivered a new inhaler on 3/12/25
Staff will be re-educated on medication procedures by the resident wellness director on 3/18/2025 see attached agenda
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication cart audits starting on 3/25/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

185a - Implement Storage Procedures

31. 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 #8's Pro Re Nata (PRN) Glutose15 Gel and Albuterol AFA 90 MCG inhaler were not available in the home.

Resident #1 has an order for a blood glucose readings twice daily. On 2-5-25 at 8:53 p.m. the Medication Administration Record (MAR) notes a reading of 210, the reading was not in the residents glucometer.

Repeat Violation: 3-7-24 et al, 1-3-24

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

Residents PRN medications have that were not available have been re-ordered.
Pharmacy conducted a cart audit on 3/11/2025, see attached
Staff will be re-educated on medication procedures by the resident wellness director on 3/18/2025 see attached agenda
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication cart audits starting on 3/25/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented ([redacted] - 05/20/2025)

187a - Medication Record

32. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident # 6's albuterol sol 2.5gm/3ml was discontinued on 1/27/25 but is still noted on the MAR.

Resident # 2 has an order to for Novolog to be administered on a sliding scale at 8:00 a.m., 12:00 p.m., and 4:00 p.m. From 2/1-2/12/25 the MAR does not indicate how many units of insulin were administered per the sliding scale.

Repeat Violation: 1-3-24

Plan of Correction ***Accept ([redacted] - 03/21/2025)***

Resident #2's units were not being documented in the MAR due to a software set up error. This error was corrected on 2/13/2025, see attached MAR to reflect ongoing documentation of [redacted] glucose and units administered.
Resident #6's albuterol order was discontinued on 2/28/2025 by [redacted] MD.
To assist with compliance, pharmacy conducted a cart audit on 3/11/2025, see attached

187a - Medication Record (continued)

Staff will be re-educated on medication procedures by the resident wellness director on 3/18/2025 see attached agenda
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication cart audits starting on 3/35/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented (- 05/20/2025)

187b - Date/Time of Medication Admin.

33. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #6's amlodipine 10mg, meloxicam 7.5mg, preservision AREDS, vitamin D 2000 units, and apap arthritis 650mg were not initialed as administered on the MAR on 2/7/25 at 8:00 a.m.

Plan of Correction ***Accept (- 03/21/2025)***

On 2/18/2025 staff were educated of this regulation by the Interim Executive Director, see attached meeting minutes.
Staff will be re-educated on medication procedures by the resident wellness director on 3/18/2025 see attached agenda
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication/MAR cart audits starting on 3/25/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented (- 05/20/2025)

187c - Refusal of Medication

34. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident # 7 refused the prescribed poly glycol powder from 2/1-2/4/25 and 2/8-2/11/25 at 8:00 a.m. The prescriber was not notified regarding the refusals.

Resident # 7 refused the prescribed melatonin 5mg at 8:00 p.m. on 2/9/25. The prescriber was not notified regarding the refusal.

187c - Refusal of Medication *(continued)*

Plan of Correction ***Accept (- 03/21/2025)***

Resident #7's medications were changed to PRN on 2/14/2025 as prefers to take them if needs them and not daily
To assist with compliance, pharmacy conducted a cart audit on 3/11/2025, see attached
Staff will be re-educated on medication procedures by the Resident Wellness Director on 3/18/25
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication cart audits starting on 3/25/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented (- 05/20/2025)

187d - Follow Prescriber's Orders

35. Requirements

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

Description of Violation

Resident # 6 has an order for meclizine 12.5 mg one tablet every eight hours as needed. On 2/10/25 the medication was administered at 1:26 p.m. and 7:52 p.m.

Resident # 1 has an order for blood glucose readings twice daily 8:00 a.m. and 8:00 p.m. The blood glucose reading on 2-5-25 at 8:00 p.m. was not completed.

Repeat Violation: 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

On 2/18/2025 staff were educated of this regulation by the Interim Executive Director, see attached meeting minutes.
Staff will be re-educated on medication procedures by the resident wellness director on 3/18/2025 see attached agenda
To ensure compliance of this regulation, the Executive Director or Designee will conduct medication/MAR cart audits starting on 3/25/2025 and will continue monthly for 6 months
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented (- 05/20/2025)

190c - Record of Training

36. Requirements

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

190c - Record of Training *(continued)*

Description of Violation

Staff Member E was certified to pass medications on 11-29-24. The staff member did not sign the Summary and Qualification form for the Medication Administration Training Course.

Staff Member A was certified to pass medications on 10-30-24. The staff member did not sign the Summary and Qualification form for the Medication Administration Training Course.

Plan of Correction ***Accept (- 03/21/2025)***

Both employees signed their summary and qualification, see attached
In order for all med techs to obtain certificate, they must complete a "Student Acknowledgement of Training" online. Going forward, all students will do both acknowledgements, online and signing the qualification form.
Starting on 3/17/2025, the Executive Director will conduct Employee file audits every month for 6 months. The audit binder will be maintained in the Executive Directors Office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

224a - Preadmission Screen Form

37. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident # 5 had multiple respite stays in the home from The home did not complete a Preadmission Screening for the resident for the previously noted respite stays.

Plan of Correction ***Accept (- 03/21/2025)***

On 3/11/2025 the Resident Wellness Director and the Resident Care Coordinator were trained on Meeting the Needs of the Resident based off of the Pre-Admission Screen, DME, and RASP by the Regional Operations Specialist, see attached sign in and PPT.
To ensure compliance, effective immediately, the Director of Community relations will start a new resident checklist to ensure completion of all required documents. See attached
Also, the Executive Director will conduct resident file audits (see attached) beginning 3/24/2025 every month for 6 months. The audit binder will be maintained in the Executive Directors office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

224a - Preadmission Screen Form *(continued)*

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)

225a - Assessment 15 Days

38. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident # 3 was admitted to the home on , the home did not complete an assessment.

Repeat Violation: 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

Residents RASP was completed on 2/18/2025
On 3/11/2025, the Resident Wellness Director and Resident Care Coordinator were trained on Meeting the needs of the resident based on the Pre-admission Screen, DME and RASP by the regional operations specialist.
Also, the Executive Director will conduct resident file audits (see attached) beginning 3/24/2025 every month for 6 months. The audit binder will be maintained in the Executive Directors office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Not Implemented (- 05/20/2025)

227d - Support Plan Medical/Dental

39. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #4's Resident Assessment and Support Plan (RASP) dated notes bed enabler can used for assistance with repositioning and getting in and out of bed. The RASP does not include the resident's ability to use the device safely for the intended purpose, any risks associated with the device and if a cover is required to meet FDA guidelines.

Repeat Violation: 10-24-24, 3-7-24 et al, 1-3-24

Plan of Correction ***Accept (- 03/21/2025)***

Resident's RASP has been updated to include residents' ability to use the device safely for the intended purpose and any
On 3/14/2025 staff were educated on the use of mobility devices by the Interim Executive Director see attached sign in
Also, the Executive Director will conduct resident file audits (see attached) beginning 3/24/2025 every month for 6

227d - Support Plan Medical/Dental (continued)

months. The audit binder will be maintained in the Executive Directors office.
Compliance will be monitored by the leadership team through the quality management meeting, next meeting is scheduled 4/1/2025 (see attached agenda)

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented (- 05/20/2025)