

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

June 9, 2025

[REDACTED], VP OPERATIONS  
HIDDEN MEADOWS OPCO LLC  
[REDACTED]  
[REDACTED]  
[REDACTED]

RE: HIDDEN MEADOWS ON THE RIDGE  
THE LAURELS  
340 FARMERS LANE  
SELLERSVILLE, PA, 18960  
LICENSE/COC#: 14524

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/06/2025 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: *HIDDEN MEADOWS ON THE RIDGE THE LAURELS* License #: *14524* License Expiration: *07/20/2025*  
 Address: *340 FARMERS LANE, SELLERSVILLE, PA 18960*  
 County: *BUCKS* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *HIDDEN MEADOWS OPCO LLC*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *03/05/2014* Issued By: *West Rockhill Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *84* Waking Staff: *63*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *03/06/2025*

**Inspection Dates and Department Representative**

*03/06/2025 - On-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: *50* Residents Served: *42*

Secured Dementia Care Unit  
 In Home: *Yes* Area: *The Laurels* Capacity: *50* Residents Served: *42*

Hospice  
 Current Residents: *2*

Number of Residents Who:  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *42*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *42* Have Physical Disability: *0*

**Inspections / Reviews**

**03/06/2025 - Full**  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/10/2025*

**04/17/2025 - POC Submission**  
 Submitted By: [REDACTED] Date Submitted: *04/26/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *04/27/2025*

Inspections / Reviews (*continued*)

06/09/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/26/2025

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 03/06/25, at 3:15pm, the narcotic book was found at the C hall medication cart; it was unlocked, unattended, and accessible to any non-medical personnel.

Plan of Correction

Accept ( [redacted] - 04/17/2025)

Immediately during inspection Narc book was removed from medication cart.

On Wednesday, March 26, 2025 staff in-services were held and the topic of privacy and confidentiality were discussed. Please see attachments on this training.

Memory Care Director starting the week of March 31, 2025 will be conducting daily audits to make sure no Narch books, or any other information is available to be seen by non-direct care staff. All binders or information will be located in a secured area at all times.

Executive Director will review audits on a weekly basis for the next two months or until substantial compliance has been achieved. In addition, Executive Director along with all department heads will be reviewing this violation and plan of correction during quarterly QA meetings. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 05/31/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ( [redacted] - 06/09/2025)

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 [redacted], for resident #1 was not signed by the resident.

The resident-home contract dated [redacted], for resident #2 was not signed by the resident.

Plan of Correction

Accept ( [redacted] - 04/17/2025)

The resident-home contract dated [redacted] for resident #1 was presented to resident for signature but resident refused to sign. Documented resident's refusal to sign.

The resident-home contract dated [redacted] for resident #2 was presented to resident for signature. Resident refused to sign due to lack of understanding. Documented resident's refusal to sign.

25b - Contract Signatures (continued)

Sales Director along with Memory Care director reviewed all remaining contracts to make sure contracts were signed by Administrator or a designee, the resident and the payor.

Executive Director or designee will review all contracts for 2 months or until substantial compliance has been achieved.

Executive Director along with all department heads will be reviewing this violation and plan of correction during quarterly QA meetings. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/07/2025

Implemented (████) - 06/03/2025)

54a - Direct Care Staff

3. Requirements

2600.

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

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept (████) - 04/17/2025)

Executive Director reviewed employee's record to make sure a waiver was not submitted prior to inspection.

Employee was hired as a PRN Care Manager back on ██████████

Executive Director could not find any past waiver, therefore submitted a new waiver asking that █████ HS Diploma from ██████████ would be accepted.

Executive Director provided additional information such as PA driver's license and completed direct care staff training.

Business Office Director and Assistant will review remaining employee files to make sure each has a High School Diploma or higher education.

A staffing check list is being used for each new hire to make sure all hiring requirements are being meet.

Executive Director or designee will review all new hires to review compliance checklist for two 2 months or until substantial compliance has been achieved.

All new staff added to Hidden Meadows The Laurels will be discussed and file reviewed at quarterly QA meeting to make sure all departments are following new hire mandatory requirements. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/07/2025

54a - Direct Care Staff (continued)

Implemented (█) - 06/09/2025)

57b - 1 Hour/Day

4. Requirements

2600.

57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 03/01/25, there were 42 residents in the home, requiring a minimum of 84 hours of direct care service. On this day, only 77 hours of direct care staffing was provided.

Plan of Correction

Accept (█) - 04/17/2025)

Staffing Coordinator, Dementia Coordinator and Wellness Director were in-serviced by Executive Director on April 2, 2025 on regulatory required staffing ratios based on current census.

Administration reviewed current schedule along with "OnShift" staffing platform for accuracy.

Health and Wellness Director or designee will complete weekly audits by running both OnShift reports and time and attendance to ensure daily hours are being worked based on daily census and that each resident is receiving 2 hours of care. Weekly Audits will continue weekly for 2 months or until substantial compliance is achieved.

Weekly staffing meeting held with Health and Wellness Director, Memory Care Director, Staffing Coordinator, and Executive Director will review staffing patterns for 2 months or until substantial compliance achieved. QA meetings quarterly to make sure all departments are aware of the requirements for staffing needs daily. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented (█) - 06/03/2025)

57d - Waking Hours

5. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 03/01/25, a total of 84 hours of direct care was required. However, only 58 of the required hours, or 69 percent, were provided during waking hours.

Plan of Correction

Accept (█) - 04/17/2025)

Staffing Coordinator, Dementia Coordinator and Wellness Director were in-serviced by Executive Director on April 2, 2025 on regulatory required hours during waking hours based on current census.

Administration reviewed current schedule along with "OnShift" staffing platform to make sure all staff were listed

57d - Waking Hours (continued)

correctly according to payroll.

Health and Wellness Director will complete weekly audits by running both OnShift reports and time and attendance to ensure 75% of direct care staffing hours are occurring during daytime hours 7am-11pm. Weekly Audits will continue weekly for 2 months or until substantial compliance is achieved.

Weekly staffing meeting held with Health and Wellness Director, Memory Care Director, Staffing Coordinator, and Executive Director will review staffing patterns. QA meetings quarterly to make sure all departments are aware of the requirements for staffing needs daily. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

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

65g - Annual Training Content

6. 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

Staff person B did not receive training in falls and accident prevention during training year January 2024 to December 2024.

Plan of Correction

Accept ( [redacted] - 04/17/2025)

Staff person B will receive additional training for falls and accident prevention along with completing mandatory training requirements for 2025.

Executive Director or designee will audit all employees who work in dementia unit related to completing mandatory trainings such as falls and accident prevention. Training will be provided to any employees lacking the required training.

Executive Director provided education regarding mandatory training requirements during staff meeting on March 26, 2025.

Training compliance will be reviewed each quarter during QA meetings. Those employees who are not meeting targeted hours will be identified. Next QA meeting is scheduled for 4/24/25. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

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

81b - Resident Personal Equipment

7. 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

Resident #1's bed enabler was not attached to the bed frame. The enabler has movement, which could potentially be an entrapment for the resident.

Resident #3's bed enabler was not attached to the bed frame, and the space between the bars is exceeding FDA guidelines. The measurement between the bars was 11 inches wide and 10 inches in height.

Plan of Correction

Accept ( [redacted] ) - 04/17/2025

Immediately during inspection, Facilities Director removed resident #1 current bed enabler and replaced it with another enabler that was attached to the bedframe.

Facilities Director along with Memory Care Director attached resident #3 enabler and installed a cover to eliminating the space between the bars. Resident # 3 is no longer a resident of The Laurels.

Weekly Audits will be completed by Executive Director or designee to make sure all bed enablers are attached, and a cover is present between any space. audits will continue for 2 months or until substantial compliance is achieved.

During quarterly QA meetings, total number of bed enablers will be discussed and reviewed to make sure compliance is being met. Next QA meeting is scheduled for 4-24-25. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

Implemented ( [redacted] ) - 06/09/2025

85a - Sanitary Conditions

8. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 03/06/25 at 10am, the freezer did not have a basket to collect the ice; the freezer ice machine kept making ice and spilling it inside the freezer. Potentially, for ice to fall out of the freezer and cause hazardous condition.

Plan of Correction

Accept ( [redacted] ) - 04/17/2025

Basket to collect ice was added immediately during inspection to prevent any hazardous condition.

Maintenace staff have been educated to make sure all common area refrigerators have an ice basket in place. If

85a - Sanitary Conditions (continued)

refrigerator is not in use, Maintenance will turn unit off for that location.

Executive Director has added this audit to weekly audit list and will continue for two months or until substantial compliance is achieved.

All equipment including refrigerators will be discussed at QA meetings to make sure they are working correctly, and all parts are included such as ice tray or basket. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ( [redacted] ) - 06/09/2025

101o - Walls, Floors, Ceilings

9. Requirements

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The rug had loose threads, was ripped, and was lifted, posing a tripping hazard condition in bedroom B-4.

Plan of Correction

Accept ( [redacted] ) - 04/17/2025

Facilities Director immediately started working on ripped and loose rug at residents B-4 room entry. Rug has been fixed and in hazard free condition.

Resident areas were discussed by Executive Director at all member staff meetings held at 7:30am and 2:00pm on 3-26-25. Staff were all instructed to make sure resident rooms, entrances, bathrooms and all common areas are free of hazards. All team members instructed to contact Maintenance immediately or their direct Supervisor.

Executive Director along with Facilities Director will be doing weekly walk arounds throughout the facility including resident rooms. Audits will continue for 2 months or until substantial compliance achieved.

Audits for weekly walk arounds will be discussed at quarterly QA meetings. The next meeting is planned for 4-24-25. Minutes of this meeting will be documented and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

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

103g - Storing Food

10. Requirements

2600.

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

103g - Storing Food (continued)

**Description of Violation**

*The frozen tilapia, eggs patty, and pastry dough in the freezer were opened and unsealed.*

**Plan of Correction**

**Accept ( [REDACTED] - 04/17/2025)**

*Items found to be opened such as tilapia, egg patties and pastry dough were immediately thrown out by Culinary Director on scene.*

*Culinary staff were educated on the spot to make sure all food items are labeled correctly and stored appropriately.*

*Executive Director and or Culinary Director will be completing weekly audits to make sure food items are labeled and stored appropriately. Audits will continue for 2 months or until substantial compliance achieved.*

*Executive Director discussed this violation at team meeting held on 3-6-25 and made all staff aware if they see food to stored correctly or not labeled to immediately report to Director. If Director is not available to please discard food item.*

*Food Service food storage audits will be discussed at quarterly QA meetings. The next QA meeting will be held on April 24, 2025. Minutes of this meeting will be documented and filed.*

**Licensee's Proposed Overall Completion Date: 04/24/2025**

**Implemented ( [REDACTED] - 06/09/2025)**

103i - Outdated Food

**11. Requirements**

2600.

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

**Description of Violation**

*There was an unlabeled, undated sausage patty in the freezer. A dented lemon-filled can was found in the food pantry.*

**Plan of Correction**

**Accept ( [REDACTED] - 04/17/2025)**

*Culinary Director on scene immediately threw out dented can along with unlabeled sausage patties.*

*Culinary staff were educated on the spot to make sure all food items are labeled correctly and stored appropriately.*

*Executive Director and or Culinary Director will be completing weekly audits to make sure food items are labeled and stored appropriately. Audits will continue for 2 months.*

*Executive Director discussed this violation at team meeting held on 3-6-25 and made all staff aware if they see food to stored correctly or not labeled to immediately report to Director. If Director is not available to please discard food item.*

*Food Service food storage audits will be discussed at quarterly QA meetings. The next QA meeting will be held on April 24, 2025. Minutes of this meeting will be documented and filed.*

103i - Outdated Food (continued)

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented (████) - 06/03/2025

132b - Safety Inspection/Fire Drill

12. 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 last fire drill observed by a fire safety expert was conducted on 01/15/2024.

Plan of Correction

Accept (████) - 04/17/2025

Immediately after inspection, Executive director reached out to Fire Safety expert to set up a Supervised Fire Drill for The Laurels. Fire Safety expert came out on March 17, 2025, and provided a supervised Fire Drill along with written documentation.

Executive Director has educated Facilities Director on regulation requiring a Supervised Fire Drill is required annually by the fire safety expert.

Supervised Fire Drills will be recorded on monthly fire drill spreadsheets to maintain compliance along with documentation. Executive Director or designee will audit fire drills spreadsheet for 2 months or until substantial compliance is achieved.

Fire Drills along with Supervised Drills will be discussed at each quarterly QA meeting. The next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

Implemented (████) - 06/03/2025

132e - Fire Drill Sleeping Hours

13. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 08/31/2024 at 6:30 am. The previous sleeping hours fire drill was conducted on 12/26/2023.

Plan of Correction

Accept (████) - 04/17/2025

Overnight Fire Drill was conducted by Facilities Director on March 11, 2025 at 11:10pm for The Laurels building.

132e - Fire Drill Sleeping Hours (continued)

Executive Director has educated Facilities Director on regulation requiring a sleeping hours fire drill needs to occur once every 6 months.

Executive Director will review each monthly Fire Drill and make sure one overnight drill is scheduled each 6 months.

Compliance will be monitored during quarterly QA meets. Next meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

Implemented ( ) - 06/03/2025

162e - Menu Changes

14. Requirements

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 03/06/25, shrimp scampi, salad were listed on the menu for the lunch meal. Brisket steak on a bun was served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction

Accept ( ) - 04/17/2025

Culinary expert present during this inspection realized a menu change was not made substituting the shrimp scampi with brisket steak.

Executive Director educated culinary team that notification needs to occur anytime there is a menu change.

Weekly audits will be conducted by Executive Director to ensure meals served are following the weekly menu schedule. Audits will continue for 2 months or until substantial compliance achieved.

Audits and findings will be shared with Director of Culinary at QA quarterly meetings. The next meeting is scheduled for April 24, 2025.

A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented ( ) - 06/03/2025

184a - Resident's Meds Labeled

15. Requirements

184a - Resident's Meds Labeled (continued)

2600.

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

**Description of Violation**

*The pharmacy label for resident #4's Levemir and Insulin Aspart Vial does not include the pharmacy label.*

**Plan of Correction**

*Accept (█ - 04/17/2025)*

*Health and Wellness Director immediately during inspection made sure pharmacy label was added to resident # 4's Levemir and insulin Aspart Vial.*

*Health and Wellness Director provided education to nursing department to make sure all medication includes a pharmacy label.*

*Health and Wellness Director or Nursing department will complete weekly medication cart audits for two months or until substantial compliance is achieved.*

*Medication audits will be reviewed quarterly during QA to make sure all medication has a pharmacy label in place. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 06/12/2025*

**Licensee's Proposed Overall Completion Date: 04/25/2025**

*Implemented (█ - 06/09/2025)*

185a - Implement Storage Procedures

**16. Requirements**

2600.

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

**Description of Violation**

*Resident #2 is prescribed Naloxone .4mg/ml vial, spray into nostril for opioid overdose as needed. On 03/06/25 this medication(s) was not available in the home.*

*Resident #4 is prescribed a blood sugar check before meals and at bedtime:*

*On 02/27/25 at dinner, the glucometer had a reading of 239, and the MAR was updated with a reading of 283.*

*On 02/27/25 at 11:30 am, the glucometer did not have a reading, and the MAR was updated with a reading of 183.*

*On 3/02/25 at bedtime, the glucometer had a reading of 172, and the MAR was updated with a reading of 174.*

*On 03/06/25, resident #5's glucometer was not calibrated with the correct date and time. The glucometer was calibrated with a date of 02/28/25 and a time of 7:59 pm. The correct date and time were 03/06/25 at 4:13 pm.*

*Resident #5 is prescribed Accu-Chek before meals and at bedtime. The MAR was updated with glucose readings. However, the readings were not registered on the glucometer from March 1, 2025, and March 3, 2025.*

185a - Implement Storage Procedures (continued)

Repeat Violation 04/04/25

**Plan of Correction**

Accept (█) - 04/17/2025)

Each glucometer was recalibrated by nursing department after inspection on March 6, 2025.

Health and Wellness Director completed re-educated of all staffed licensed practical nurses on the process for re calibrating glucometers to correct date and time.

As an ongoing measure, Health and Wellness Director will also conduct weekly audits beginning 4-9-25 to ensure glucometers are properly reading correct dates/times and if there is an additional need to re calibrate. Audits will continue for two months or until substantial compliance to make sure all glucometers are accurate, and documentation is consistent.

Executive Director will review audits for glucometers at quarterly QA meetings.

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented (█) - 06/09/2025)

187b - Date/Time of Medication Admin.

**17. 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 #4 is prescribed Lorazepam Tab .5mg, give one tablet orally every 6 hours as needed for anxiety. Resident #4's March 2025 medication administration record does not include the initials of the staff person who administered Lorazepam on 03/02/25 at 7:29 pm.

Repeat Violation 04/04/25.

**Plan of Correction**

Accept (█) - 04/17/2025)

Health and Wellness Director immediately educated nurses and medication techs on requirement to document all medication given on MAR including initials.

On March 10, 2025 Health and Wellness Director started conducting in-service training that included All medications given must be noted in the MAR with initials.

Weekly audits will be conducted by Health and Wellness Director to make sure all PRN medication is being signed out correctly on both narc book but as well on MAR, including initials. Audits will continue for two months or until

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

substantial compliance achieved.

Executive Director will review audits during quarterly QA meetings. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented (█) - 06/09/2025)

**187d - Follow Prescriber's Orders****18. Requirements**

2600.

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

**Description of Violation**

Resident #4 is prescribed Novolog 100-unit/ML vial inject subcutaneously before meals and at bedtime based on a sliding scale. On 02/27/25, the resident's lunchtime blood sugar level was not checked. However, the MAR was updated with a reading of 183.

Resident #5 is prescribed Accu-Chek before meals and at bedtime. The MAR was updated with glucose readings. However, the readings were not registered on the glucometer from March 1, 2025, and March 3, 2025.

The following reading was recorded on the MAR.

On 03/01/25 at 8am, the MAR was updated with a reading of 105, and the glucometer reading was missing.

On 03/01/25 at 11:30am, the MAR was updated with a reading of 294, and the glucometer reading was missing.

On 03/01/25 at 4:30pm, the MAR was updated with a reading of 409, and the glucometer reading was missing.

On 03/01/25 at 9pm, the MAR was updated with a reading of 306, and the glucometer reading was missing.

On 03/02/25 at 8am, 11:30am, 4:30pm, and at 9pm. The MAR had readings of 198, 270, 261, and 261. The glucometer readings were missing for those times.

Repeat Violation 04/04/25.

**Plan of Correction**

Accept (█) - 04/17/2025)

On March 10, 2025 Health and Wellness Director started conducting in-service training that included Glucometer training on calibration and documentation. All staff responsible for using resident's glucometers will make sure the number in MAR matches the exact number in the glucometer. Staff were also reminded to follow all prescriber's orders to make sure all residents receive Accu-cheks as ordered.

Health and Wellness Director will begin weekly audits starting the week of April 6, 2025, to ensure that staff are accurately utilizing and recording glucometer readings. Audits will continue for 2 months or until substantial compliance achieved..

Executive Director will review glucometer audits during quarterly QA meetings. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

187d - Follow Prescriber's Orders (continued)

Proposed Overall Completion Date: 06/12/2025

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented (████) - 06/09/2025)

190c - Record of Training

19. Requirements

2600.

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

Description of Violation

The home's medication administration training record for staff person C does not include documentation of successful completion of the training.

Plan of Correction

Directed (████) - 04/17/2025)

Current Executive Director reviewed Staff person C record and █████ did finish the course prior. We thought everything was in place for █████ record, but the previous train the trainer needed to finalize something on █████ end to produce the actual certification.

When this happened the date of completion showed March 12, 2025. This would appear █████ was trained after the inspection on March 6, 2025. A summary from each QA meeting will be drafted and filed.

Health and Wellness Director will review all current medication techs to see if they have the required certification that went into effect 1-1-24.

Home now has a new train the trainer and they have been instructed to make sure training certification is printed out and placed in employee's record.

Executive director will review all medication techs with QA group and make sure all certifications are printed out and placed in each employee's record.

Proposed Overall Completion Date: 04/24/2025

Directed Plan of Correction (slw 4/17/25):

\*the director will provide the med training for staff C to the Department for review. Staff C will continue to complete the required annual practicum in accordance with the completion date of the original training date.

Directed Completion Date: 04/24/2025

Implemented (████) - 06/03/2025)

224a - Preadmission Screen Form

20. Requirements

2600.

224a - Preadmission Screen Form (continued)

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 #2 was admitted to the home on [REDACTED] however, the resident's preadmission screening form was not dated.

Plan of Correction

Accept ([REDACTED] - 04/17/2025)

Health and Wellness Director updated the date of preadmission screening for resident #2.

All current residents' charts will be reviewed by Executive Director or Director of Memory Care to make sure prescreens are completed appropriately and accurately. If there are any prescreens that are not complete, the Director of Health and Wellness will be instructed to complete missing sections. Audit tool will be used to keep track of compliance.

Executive Director provided a 1:1 in-service for Wellness Director on making sure the prescreen is completed entirely including signature and date.

Executive Director will audit all new residents required paperwork including the prescreen to make sure all sections have been completed. Audits will continue for 2 months or until substantial compliance achieved.

During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure all required forms such as the prescreen have been completed. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

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

225a - Assessment 15 Days

21. 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

An assessment was not completed for resident #2, who was admitted to the home on [REDACTED]

Plan of Correction

Accept ([REDACTED] - 04/17/2025)

Health and Wellness Director Resident #2 completed the 15 day assessment for resident #2, by 4/25/25.

All current residents' charts will be reviewed by Executive Director or Director of Memory Care to make sure assessments and RASPS are completed appropriately and accurately. If there are any documents that are not completed the Director of Health and Wellness will be instructed to complete missing sections. Audit tool will be used to keep track of compliance.

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

*Executive Director provided a 1:1 in-service for Wellness Director on making sure the prescreen is completed entirely including signature and date.*

*Executive Director will audit all new residents required paperwork including the prescreen to make sure all sections have been completed. Audits will continue for 2 months or until substantial compliance achieved.*

*During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure all required forms such as 15 day assessments have been completed. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 04/24/2025*

**Licensee's Proposed Overall Completion Date: 04/24/2025**

**Implemented (████ - 06/03/2025)**

**231b - Medical Evaluation****22. Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

**Description of Violation**

*Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on ██████ however, the resident's medical evaluation was completed on ██████*

**Plan of Correction**

**Accept (████ - 04/17/2025)**

*Health and Wellness Director was educated by Executive Director following the inspection on March 6, 2025 on the requirements of having a medical evaluation completed 60 days prior to admission.*

*All current residents' charts will be reviewed by Executive Director or Director of Memory Care to make sure medical evaluations are completed appropriately and accurately within 60 days of admission. Audit tool will be used to keep track of compliance for all current residents of the home.*

*Executive Director will audit all new residents required paperwork including medication evaluation making sure it is completed before actual admission date. Audits will continue for 2 months or until substantial compliance achieved.*

231b - Medical Evaluation (continued)

During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure all required forms such as the medical evaluation have been completed. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

Implemented ( [REDACTED] - 06/09/2025)

231c - Preadmission Screening

23. 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 #5 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, resident #5's written cognitive preadmission screening was completed on [REDACTED]. Also, resident #5's cognitive screening was not completed entirely; it was missing the diagnosis and the title of the person completing the screening.

Plan of Correction

Accept ( [REDACTED] - 04/17/2025)

Resident #5 cognitive preadmission screening has been updated to include diagnosis and person completing the screening.

Executive Director provided a 1:1 in-service for Wellness Director on making sure the cognitive prescreen is completed entirely.

All current residents' charts will be reviewed to make sure prescreens are completed appropriately and accurately. Audit tool will be used to keep track of compliance.

Executive Director will audit all new residents to ensure all sections on prescreen have been completed.

During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure all required forms such as the prescreen have been completed. Next QA meeting is scheduled for April 24, 2025. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 04/24/2025

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

236 - Staff Training

24. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU), had only 4 hours of training in dementia care during the calendar year of January 2024 and December 2024 training year.

Plan of Correction

Accept ( [REDACTED] - 04/17/2025)

Staff person C will receive two additional training hours for dementia along with completing mandatory training requirements for 2025, for a total of 8 hours of training in Dementia.

Dementia Coordinator has begun dementia training for direct care staff as part of in person "shine" training.

Executive Director will audit all employees who work in dementia unit to identify if mandatory 6 hours of training related to dementia care and services was received.

Training compliance will be reviewed each quarter during QA meetings. Those employees who are not meeting targeted hours will be identified. Next QA meeting is scheduled for 4/24/25. A summary from each QA meeting will be drafted and filed.

Proposed Overall Completion Date: 04/24/2025

Licensee's Proposed Overall Completion Date: 04/24/2025

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