pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **EC OPCO LEWISBURG LLC**
LEGAL ENTITY

To operate **CELEBRATION VILLA OF LEWISBURG**
NAME OF FACILITY OR AGENCY

Located at **2421 OLD TURNPIKE ROAD, LEWISBURG, PA 17837**
(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 **73** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 17**

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 18, 2025** until **December 18, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **227201**

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 18, 2025

President
EC OPCO Lewisburg, LLC

RE: Celebration Villa of Lewisburg
2421 Old Turnpike Road
Lewisburg, Pennsylvania 17837
License # 227201

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on March 19, 2025 and March 26, 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 227200) dated May 8, 2025 to May 8, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued. The license dated May 8, 2025 to May 8, 2026 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 18, 2025 to December 18, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a 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

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:

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

Facility Information

Name: *CELEBRATION VILLA OF LEWISBURG* **License #**: *22720* **License Expiration**: *03/08/2025*

Address: *2421 OLD TURNPIKE ROAD, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *EC OPCO LEWISBURG LLC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/13/1998* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/14/2025*

Inspection Dates and Department Representative

03/19/2025 - On-Site: [redacted]
03/26/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *73* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *17* **Residents Served**: *13*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *36*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *20* **Have Physical Disability**: *0*

Inspections / Reviews

03/19/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/04/2025*

06/02/2025 - POC Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *06/02/2025*

Follow-Up Type: *Bypass Document Submission*

06/02/2025 - Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *06/02/2025*

Follow-Up Type: *Enforcement*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

At approximately 9:30 am on 3/26/25, the batteries in the Carbon Monoxide detector near the break room were last replaced in September 2023.

At approximately 9:20 am on 3/26/25, the batteries in the Carbon Monoxide detector located near Room #120 were not dated to indicate when they were last changed.

As per The Care Facility Carbon Monoxide Alarm Standards Act the batteries need to be replaced annually.

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On 3/19/25 new batteries were placed in a carbon monoxide detector located near the breakroom, and near room #120, by the Maintenance Director. On 3/19/25 an audit of all carbon monoxide detectors was completed by the Maintenance Director and new batteries were placed in carbon monoxide detectors.
TRAINING: On 5/2/2025 the Director of Maintenance was educated on regulation 2600.18 by the Regional Director of Operations. All staff to be educated on 2600.18, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective March 2025 all carbon monoxide detectors will be labeled with date batteries that were changed, by the Maintenance Director. Effective March 2025 all carbon monoxide detectors will be checked quarterly by the Maintenance Director and annually batteries will be changed by the Maintenance Director. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

23a - Activities of Daily Living Assistance

2. Requirements

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

Description of Violation

The Resident Assessment and Support Plan (RASP) for Resident #2, dated , indicates the need for total assistance showering and an assist of 2 staff with transfers. When interviewed, Resident #2 indicated they do not receive a shower weekly as scheduled due to a shortage of Direct Care Staff. On 2/23/25 Resident #2 was getting out of the shower with only one staff assisting. The resident lost their balance, fell to the floor and hit their head. On 1/13/25, Resident #2 rang the call bell for assistance. Records indicate the call bell rang for 19 minutes and 41 seconds before staff responded. As a result, Resident # 2 attempted to use the toilet without assistance and fell, hitting their head on the floor. Resident # 2 was sent to the hospital . Staff Person E confirmed that several residents require assistance of 2 staff for toileting and for showering, which leaves the other residents in the Secured Dementia Care Unit (SDCU) unsupervised and unattended.

23a - Activities of Daily Living Assistance (continued)

A review of the call bell logs for Resident #2 indicated the following: On 2/20/25 at 8:06 a.m. Resident #2 waited 138 minutes for assistance when utilizing the call bell system. On 2/20/25 at 8:31 p.m. the resident waited 75 minutes for assistance when utilizing the call bell system. On 2/21/25 at 7:55 a.m. the resident waited 136 minutes and 16 seconds for assistance when utilizing the call bell system. On 2/21/25 at 9:54 p.m. the resident waited 679 minutes for assistance when utilizing the call bell system. On 2/22/25 at 12:24 p.m. the resident waited 351 minutes for assistance when utilizing the call bell system. Resident #2 indicated during an interview that staff are not around for most of second shift, and when they enter the room to complete care, they are rushing through it. The resident also indicated there is never 2 staff persons assisting when personal hygiene and showers are being completed.

Resident #1, #2, #5, #6, and #7 currently reside in the home's SDCU. Per Staff interviews, all 5 Residents require a 2-person assist to safely transfer, shower, and evacuate. Per interviews completed with Staff persons C,D,F,G and H, residents who require 2 staff persons to assist them with their Activities of Daily Living (ADL) are not receiving regular showers because there are not enough staff.

Repeat Violation: 2/13/25

Plan of Correction ***Directed ([redacted] - 05/21/2025)***

ACTION: On 3/27/2025 an audit of all assessments and support plans, by the Regional Director of Clinical Services to ensure the home is providing each resident with assistance with ADLs as indicated in the residents' assessments and support plan.

TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.23a, by the Regional Director of Operations. All staff to be educated on 2600.23a, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 the Executive Director/DON shall provide copies in the nurse's office in binders for both Personal Care and SDU residents' assessments and support plans to ensure the home provides each resident with assistance with ADLs as indicated in the residents' assessments and support plan. Documentation to be kept and reviewed at month Quality Assurance.

Proposed Overall Completion Date: 05/16/2025

(Directed)
The Administrator will interview 3 residents per week to confirm their needs are being met as identified in their Resident Assessment and Support Plans for 3 months. These interviews will be documented and maintained. The Administrator will review the call bell logs for 3 residents per week for 3 months. These reviews will be documented and maintained. The Administrator will create a tool for staff persons to track the assistance with ADL's they are providing for the residents on each shift. This tool will be reviewed by the Administrator/designee daily to ensure the residents needs are being met. The Administrator will immediately address any problems encountered with care.

Directed Completion Date: *06/27/2025*

42b - Abuse

3. Requirements

2600.

42b - Abuse *(continued)*

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

Description of Violation

Resident #3 is incontinent of bladder and bowel and requires assistance from staff for incontinence care. The resident's family indicated on many occasions, they found the resident in saturated and soiled incontinence briefs, the linen soiled with what appeared and smelled like dried urine and feces, and finding soiled incontinence briefs in with the resident's dirty clothing. Staff interviews indicate upon the start of their shift (2nd), they often found the resident in saturated and soiled incontinence briefs and with what appeared and smelled to be dried urine and feces on the linens. They also indicate some staff refused to care for the resident due to being hit by the resident. It was determined the resident was allowed to remain in soiled incontinence briefs for extended periods of time, and the resident's linens were allowed to remain on the bed after being soiled long enough for the urine and feces to dry.

On 02/19/25, Resident #4 wandered into Resident #1's room. Resident #1 was observed touching [redacted] of Resident #4 under their shirt. Resident #1 was placed on 30-minute checks. While onsite on 03/19/2024, the administrator stated that Resident #1 was no longer on 30-minute checks as per physician orders. However, when staff were interviewed, they stated that they were still completing the checks because Resident #1 has a history of inappropriate behaviors, and they wanted to make sure other residents were safe around Resident #1.

Repeat Violation: 11/26/24

Plan of Correction ***Directed ([redacted] - 05/21/2025)***

ACTION: Resident #1, #3, #4, no longer resides in the community. Documentation to be kept.

TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.42b, by the Regional Director of Operations. All staff to be educated on 2600.42b, by the Regional Director of Operations by 5/15/25.
ONGOING: Beginning May 2025 Executive Director/DON/designee to hold staff meeting on a quarterly basis and review regulation 2600.42b for 1 year, ongoing all staff to be trained upon hire on mandatory abuse reporting and on an annual basis by the Executive Director. Documentation to be kept and reviewed at month Quality Assurance.

Proposed Overall Completion Date: 05/16/2025

(Directed)
In addition to the above noted plan: The Administrator will interview 3 residents per week to confirm their needs are being met as identified in their Resident Assessment and Support Plans for 3 months. These interviews will be documented and maintained. The Administrator will review the call bell logs for 3 residents per week for 3 months. These reviews will be documented and maintained. The Administrator will create a tool for staff persons to track the assistance with ADL's they are providing for the residents on each shift. This tool will be reviewed by the Administrator/designee daily to ensure the residents needs are being met. The Administrator will immediately address any problems encountered with care.

Directed Completion Date: *06/27/2025*

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Resident #2's family member reported that while they were visiting in March 2025 at the home, staff person F showed them a photo of bruising on Resident #3's "naked back and buttocks", violating Resident #3's right to privacy.

Plan of Correction ***Directed (█ - 05/21/2025)***

ACTION: On 5/2/25 staff member F was reeducated on 2600.42s.

TRAINING: All staff to be educated on 2600.42s, by the Regional Director of Operations by 5/15/25.
ONGOING: Beginning May 2025 Executive Director/DON/DON/designee to hold staff meeting on a quarterly basis and review regulation 2600.42s for 1 year, ongoing all staff to be trained upon hire on resident privacy and on an annual basis by the Executive Director. Documentation to be kept and reviewed at month Quality Assurance.

Proposed Overall Completion Date: 05/16/2025

(Directed)
The home will train all staff in the homes internal policy regarding cell phone use. Staff may not photograph or video record residents with private cell phones or other electronic devices. If the home does not have a policy, the home will immediately create one and enforce it with the staff. The Administrator will conduct weekly observations of staff following the policy immediately for 3 months. These observations will be on different days of the week, different shifts, and when different staff are working. These observations will be documented and any problems will be addressed immediately.

Directed Completion Date: *06/27/2025*

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 3/26/25 the home's current census was 36. 20 residents have mobility needs: 14 in the SDCU and 6 in Personal Care. Of the 20 residents with mobility needs, 7 require a 2 person assist and 10 require an assist of one for transfers. 3 residents in the SDCU require constant verbal queuing for evacuation. Based on information obtained from staff schedules, resident and staff interviews, it was determined that the home routinely schedules 3 direct care staff for the overnight shift (10:00 p.m.-6:00 a.m.). On 3/13, 3/15 and 3/21/25 only two staff worked the overnight shift. The home does not have enough staff on the overnight shift to meet the residents needs in the event of an emergency.

Plan of Correction ***Accept (█ - 05/21/2025)***

ACTION: On 3/20/2025 the Executive Director/DON reviewed staffing hours daily to ensure the correct amount of staffing hours is available to provide at least 2 hours per day of personal care services to each resident who has

60a - Staff/Support Plan (continued)

mobility needs.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.60a, by the Regional Director of Operations. All staff to be educated on 2600.60a, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective 3/20/25 the Executive Director/Director of Nursing will review staffing hours daily on the schedule for 3 months to ensure the correct amount of staffing hours is available to meet the needs of the residents as specified in the residents' assessments and support plan and ensure three direct care workers are scheduled on overnight shift. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (█ - 06/02/2025)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

Description of Violation

Staff person A, date of hire █ does not have training that includes a demonstration of job duties, followed by supervised practice.

Staff person B, date of hire █ does not have training that includes a demonstration of job duties, followed by supervised practice.

Staff person C, date of hire █, does not have training that includes a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept (█ - 05/21/2025)***

ACTION: On 4/15/25 direct care staff B that provides ADL services signed off on demonstration of job duties, by Regional Director of Operations. On March 2025 staff member C will no longer provide direct care to the residents. Staff member A is █ will be required to be signed off on a demonstration of job duties prior to working unsupervised in the community. Administrative Assistant to complete an audit of all direct care staff members to be completed, by 5/15/2025 to ensure that all direct care staff members were signed off on demonstration of job duties.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.65d, by the Regional Director of Operations. All staff to be educated on 2600.65d, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 all staff members that provide ADL services will be signed off on description of job duties prior to being unsupervised, and to be reviewed by Executive Director/DON and initialed prior to putting in staff file. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (█ - 06/02/2025)

65e - 12 Hours Annual Training

7. Requirements

65e - 12 Hours Annual Training *(continued)*

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff person D, date of hire [redacted] did not complete 12 hours of annual training in training year 2024.

Plan of Correction ***Accept ([redacted] - 05/21/2025)***

ACTION: Direct care staff member D to complete 12 hours of annual training relating to [redacted] job duties, by 5/15/2025.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.65e, by Regional Director of Operations. All staff to be educated on 2600.65e, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 all direct care staff members annual training relating to their job will be reviewed quarterly by the Executive Director/DON/AA, and a copy will be placed in the training binder. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented ([redacted] - 06/02/2025)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.

Description of Violation

Staff person D, date of hire, [redacted] did not complete the required training topics of medication self-administration, meeting the needs of the resident as described in the preadmission screening form, assessment tool, medical evaluation, and support plan, and care for residents with dementia and cognitive impairments in training year 2024.

Plan of Correction ***Accept ([redacted] - 05/21/2025)***

ACTION: Direct care staff member D to complete all training topics for the direct care staff person, by 5/15/2025.
TRAINING: All staff to be educated on 2600.65f, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 all direct care staff members annual training relating to their job will be reviewed quarterly by the Executive Director/DON/AA, and a copy will be placed in the training binder. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented ([redacted] - 06/02/2025)

81b - Resident Personal Equipment

9. Requirements

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

81b - Resident Personal Equipment *(continued)*

Description of Violation

The bed cane attached to Resident #2's bed was not properly secured to the bed frame posing a risk for injury to the resident.

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On 3/26/25 bed cane attached to resident #2 bed was properly secured by the Maintenance Director to ensure no injury to the resident. Resident #2 no longer resides in the community. The community does not currently have any residents with a bed cane.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.81b by the Regional Director of Operations. All staff to be educated on 2600.81b, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 any resident with an enabler bar medical trained staff will check all residents with an enabler bar daily on each shift to ensure compliance and safety. Documentation of the safety check will be kept in the resident's electronic medical record to ensure the enabler bar on each resident's bed is secure and has a cover over it. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

103e - Left Overs

10. 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 10:00 a.m. on 3/26/25 in the chest freezer in the dining room, there was an open bag of what appeared to be sausage patties, breadsticks, and frozen cookie dough that was unlabeled and undated.

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On 3/19/2025, undated food was removed from refrigeration by the cook and was thrown away. On 5/2/2025 a complete audit of the kitchen, refrigerator/freezer, was completed by the Dietary Director to ensure outdated or spoiled food or dented cans may not be used. Documentation to be kept.
TRAINING: On 4/22/2025 the Executive Director/Dietary Director was educated on regulation 2600.103e, by the Regional Director of Operations. All staff to be educated on 2600.103e, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 an audit of the kitchen, refrigerator/freezer, to be completed weekly by the Dietary Director x 3 months to ensure outdated or spoiled food or dented cans may not be used. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

105g - Lint Removal and Duct Cleaning

11. 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 9:35 a.m. on 3/26/25, an accumulation of lint was noted in the lint trap of the dryer located in the SDCU laundry room.

At approximately 9:30 a.m. on 3/26/25, an accumulation of lint was noted in the lint trap of the dryer located in the laundry room across from resident room 111.

Plan of Correction ***Accept (█ - 05/21/2025)***

ACTION: On 3/19/2025 the lint was removed from the lint trap and the drum of the clothes dryers, by the Maintenance Director.
TRAINING: On 4/22/2025 Executive Director and on 5/2/2025 Maintenance Director was educated on regulation 2600.105g, by Regional Director of Operations. All staff to be educated on 2600.105g, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 15, 2025, Med Tech will ensure that lint shall be removed from the lint trap and drum of clothes dryers end of shift daily x 3 months. Effective March 2025 the Maintenance Director will ensure the lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers monthly. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (█ - 06/02/2025)

124 - Notice to Fire Department

12. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home's most recent letter to the local fire department dated 2/27/24 indicates the home's licensed capacity is 60 residents; however, the home is licensed for 73 residents.

Plan of Correction ***Accept (█ - 05/21/2025)***

ACTION: On 5/1/25, the local fire department was notified in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency, and license capacity, by the Executive Director. Documentation of notification shall be kept. Documentation to be kept.
TRAINING: On 4/22/2025 the Executive Director, on 5/2/2025 Director of Maintenance was educated on regulation 2600.124, by the Regional Director of Operations. All staff are to be educated on 2600.124, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 the local fire department will be notified quarterly, or with any changes in writing

124 - Notice to Fire Department (continued)

to the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency, by the Executive Director. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

125a - Combustible Storage

13. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At approximately 9:35 a.m. on 3/26/25, a large amount of paper scraps and a piece of clothing was noted approximately 3 inches away from the external dryer vent behind the clothes dryer in the SDCU laundry room.

At approximately 9:30 a.m. on 3/26/25, a large amount of paper scraps and several items of clothing were noted approximately 3 inches away from the external dryer vent behind the clothes dryer in the laundry room across from room #111.

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On 3/19/2025 all combustible and flammable materials were removed near heat sources, in SDCU, and laundry room across from room #111, by Maintenance Director.
TRAINING: On 4/22/2025 the Executive Director, on 5/2/2025 Maintenance Director, was educated on regulation 2600.125a, by Regional Director of Operations. All staff to be educated on 2600.125a, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 15, 2025, housekeepers will sign off to ensure that combustible and flammable materials are not located near dryers daily. Effective 3/19/25 Maintenance Director will ensure that combustible and flammable materials are not located near the heat source, weekly. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

132d - Evacuation

15. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's most recent letter, dated June 13, 2024, from the fire safety expert indicates a safe evacuation time of 15 minutes based on the physical construction of the building. The fire drill conducted on 10/30/24 at 3:51 a.m. took 15 minutes and 32 seconds for evacuation.

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On 4/17/25, a fire drill was conducted at 10;25 PM, by Maintenance Director, to ensure the residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within the period of time specified in writing within the past year by a fire safety expert. Documentation of notification shall be kept. Documentation to be kept.
TRAINING: On 4/22/2025 the Executive Director, on 5/2/2025 Director of Maintenance was educated on regulation 132d, by Regional Director of Operations. All staff to be educated on 2600.132d, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 all fire drill are to be reviewed and initialed by the Executive Director prior to filing in binder to ensure the residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within the period of time specified in writing within the past year by a fire safety expert. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

183b - Meds and Syringes Locked

16. 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 9:03 a.m. on 3/26/25, an unlocked and unattended medication cart was found across from Executive Director's Office.

183b - Meds and Syringes Locked (continued)

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On 3/26/25 the Med cart across from the Executive Director's office was locked by Med Tech on duty.
TRAINING: On 4/22/2025 Executive Director was educated on regulation 2600.183b, by Regional Director of Operations. All staff to be educated on 2600.183b, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective 3/26/25 community manager will audit the community med carts twice weekly x 3 months to ensure prescription medications, OTC medications, and 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. Documentation to be kept and reviewed at month Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

Withdrawn 6/12/25

234a - Admission Support Plan

18. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1 was admitted to the homes SDCU on [redacted] the 72 hour RASP was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 05/21/2025)***

ACTION: On 3/27/2025 an audit of all current residents that reside in the secured dementia care unit was completed by Regional Director of Clinical Services to ensure a support plan was developed, implemented and documented in the resident record within 72 hours of admission.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.234a by the Regional Director of Operations. All staff are to be educated on 2600.234a, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 all residents admitted into the secured memory care unit will be reviewed for 3 months to ensure a support plan was developed, implemented and documented in the resident record within 72 hours of admission, by the Executive Director, prior to filing on chart. Documentation to be kept and reviewed at monthly Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented ([redacted] - 06/02/2025)

Withdrawn **6/12/25**

236 - Staff Training

20. 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

Staff person D, date of hire [redacted] did not complete the required additional 6 hours of training related to dementia care and services. Both days the Department was in the building, the staff person was observed working in the SDCU.

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: An audit to be conducted on 2024 dementia training, to be completed 5/15/2025, by Administrative Assistant. Staff member D is current for 2025 dementia training.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.236, by the Regional Director of Operations. All staff to be educated on 2600.236, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 Administrator and a member of leadership team will monitor staff training quarterly to ensure compliance of 6 annual hours of dementia training requirements/completion, by end of year.
Documentation to be kept and reviewed at monthly Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)

251b - Record Entries Legible

21. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used in the "Ability to Self-Administer Medications" section of resident # 2's medical evaluation, dated [redacted]

Plan of Correction ***Accept (- 05/21/2025)***

ACTION: On audit of all DME's to be completed by 5/15/2025 to ensure the entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry, by Executive Director/DON/designee.
TRAINING: On 4/22/2025 the Executive Director was educated on regulation 2600.251b, by Regional Director of

251b - Record Entries Legible (continued)

Operations. All staff to be educated on 2600.251b, by the Regional Director of Operations by 5/15/25.
ONGOING: Effective May 2025 all DME's will be reviewed to ensure the entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry, prior to placing in residents' chart, by Executive Director prior to placing on resident's chart x 3 months. Documentation to be kept and reviewed at monthly Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Not Implemented (- 06/02/2025)