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

July 1, 2025

[redacted], EXECUTIVE DIRECTOR
BRODHEAD SENIOR LIVING LLC
125 APPLE BLOSSOM WAY
MOON TOWNSHIP, PA, 15108

RE: APPLE BLOSSOM SENIOR LIVING
125 APPLE BLOSSOM WAY
MOON TOWNSHIP, PA, 15108
LICENSE/COC#: 45072

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/31/2025, 04/01/2025 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: *APPLE BLOSSOM SENIOR LIVING* **License #**: *45072* **License Expiration**: *12/14/2025*

Address: *125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*

Address: *125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/27/2019* **Issued By**: *Moon Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *120* **Waking Staff**: *90*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/07/2025*

Inspection Dates and Department Representative

03/31/2025 - On-Site: [redacted]

04/01/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *103*

Secured Dementia Care Unit

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

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *102*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *17* **Have Physical Disability**: *1*

Inspections / Reviews

03/31/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/01/2025*

04/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/05/2025*

Inspections / Reviews *(continued)*

05/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/01/2025*

07/01/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

25c2 - Fee Schedule

1. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Resident #1's most recent billing invoice, dated 3/1/25, includes a charge of $80 for laundry services; however, this service or the amount of the service is not indicated in resident #1's resident-home contract, dated [redacted]

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

Upon inspection of Resident #1's financial folder, the signed ([redacted] fee schedule was located. (DIRECTED: By 5/9/25: The administrator shall ensure all addendums to resident #1's resident-home contract, including resident #1's current fee schedule, are physically attached to resident #1's resident-home contract and placed in resident #1's record. [redacted] 5/6/25). See attached. Admissions department educated on all proper documentation required upon admission on 4/28/25 by the Executive Director . (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). Electronic contract has been ammeded to include the fee schedule which was effective 4/15/2025. The Executive Director or designee will audit new admissions contracts to ensure the fee schedule is included starting 4/28/25 weekly for 4 weeks. Audit will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25).

DIRECTED: By 6/1/25: The administrator/designee shall review all current resident-home contracts to ensure all resident-home contracts include the home's fee schedule, which specifies the actual amount of allowable resident charges for each of the home's available services, including the home's charges for laundry services. During the audits, the administrator/designee shall also ensure all addendums to the resident-home contracts are physically attached to the resident-home contracts. Any resident-home contract found to not include the home's fee schedule shall be provided to the resident and their designated person in writing. Documentation of notification shall be kept. [redacted] 5/6/25

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *06/01/2025*

Implemented ([redacted] - 07/01/2025)

25c8 - Smoking

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
8. The home's rules related to home services, including whether the home permits smoking.

Description of Violation

Resident #1's resident-home contract, dated [redacted]*, does not include the home rules.*

Resident #2's resident-home contract, dated [redacted] *does not include the home rules.*

25c8 - Smoking *(continued)*

Plan of Correction ***Directed (- 05/06/2025)***

Upon inspection of Resident #1 and #2 financial folders the addendum for the facility smoking policy was located. (DIRECTED: By 5/9/25: The administrator shall ensure all addendums to resident #1 and #2's resident-home contracts, including the home's home rules, are physically attached to resident #1 and #2's resident-home contracts and placed in resident #1 and #2's records. 5/6/25). See attached. Admissions department educated on all proper documentation required upon admission on 4/9/25 by the Executive Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Electronic contracts was ammeded to include home rules on 4/15/2025. The Executive Director or designee will audit new admission contracts for inclusion of the home rules starting 4/28/25 weekly for 4 weeks, starting 4/28/2025 through 5/23/25. Audit will be reviewed at the quality management meeting on 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25).

DIRECTED: By 6/1/25: The administrator/designee shall review all current resident-home contracts, including the resident-home contracts for residents #1 and #2, to ensure all resident-home contracts include the home's home rules, including the home rules relating to smoking. During the audits, the administrator/designee shall also ensure all addendums to the resident-home contracts are physically attached to the resident-home contracts. Any resident-home contract found to not include the home's home rules shall be provided to the resident and their designated person in writing. Documentation of notification shall be kept. 5/6/25

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *06/01/2025*

Implemented (- 07/01/2025)

81b - Resident Personal Equipment

3. 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

On 3/31/25, numerous bed enablers were not securely attached to the resident bed frames, to include the bed enablers on residents #3, #4 and #5's beds.

Plan of Correction ***Directed (- 05/06/2025)***

On 3/31/25 the bed enablers were immediately secured for Residents #3, #4, #5 by Powerback physical therapist. The residents utilizing bed enabler's were audited on 3/31/25 for proper securement and the need for continued use. Direct care staff and therapy department educated on 4/9/25 for proper use and securing of bed enablers by the Executive Director (ED). (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Residents with bed enabler bars will be audited for proper securement by the ED or designee daily for 2 weeks and then weekly for 2 weeks, starting 4/28/2025 then monthly. Audit results will be reviewed at the quality management meeting on 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25)

Proposed Overall Completion Date: 05/23/2025

81b - Resident Personal Equipment *(continued)*

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 3/31/25 at approximately 10:45 AM, there were no paper towels, hand dryer or other sanitary means of hand drying present at the 1st floor service sink.

Plan of Correction ***Directed (- 05/06/2025)***

The batteries were immediately changed in the paper towel dispenser on 3/31/25 and was properly functioning. No residents were affected. Inspected other paper towel dispensers in the home and all were in working condition . Kitchen staff educated on 4/9/25 by the Executive Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Audit of the paper towel dispensers in the home for proper functionality to be completed by the Executive Director or designee weekly for 4 weeks, starting 4/28/2025. (DIRECTED: At least 5 different sinks shall be checked during each audit to ensure sanitary conditions are maintained. At the conclusion of the weekly audits, the administrator/designee shall audit at least 5 different sinks monthly to ensure sanitary conditions are maintained. 5/6/25). Audit results will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25).

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 3/31/25 at 11:32 AM, no operable lamps or other source of lighting were present at resident #3 and #6's bedsides.

Plan of Correction ***Directed (- 05/06/2025)***

The lamp was immediately placed within resident's #3 and #6's reach on 3/31/25. 100% audit completed on all rooms on 3/31/25. No other residents affected. Direct care staff education on lighting/operable lamp completed on 4/9/25 by the Executive Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Move in coordinator will complete a move in check list upon admission starting on 4/28/25. ED or designee will complete a random sample audit of 5 residents weekly x 4, starting 4/28/2025 then monthly. Audit results will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25),

101j7 - Lighting/Operable Lamp (continued)

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 3/31/25 at 11:04 AM, a refrigerator was present in front of the emergency exit door leading from the boiler room to the outside of the home, blocking this egress route.

Plan of Correction ***Directed (- 05/06/2025)***

On 3/31/25 the refrigerator was immediately removed from the egress pathway by the assistant maintenance director. All egress routes were inspected by the maintenance director and confirmed to be all clear and accessible on 4/1/25 . Assistant Maintenance director educated along with all current staff on 4/9/25 on maintaining clear egress pathways. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Executive Director will complete an audit of egress exits for clear pathway weekly x 4 starting 4/28/2025 then monthly. (DIRECTED: An audit of all stairways, hallways, doorways, passageways and egress routes from rooms and from the building shall be completed during each audit to ensure they are unlocked and unobstructed. 5/6/25). Audit results will be reviewed at the quality management meeting 5/28/25 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25).

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

127a - Portable Space Heaters

7. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 3/31/25 at approximately 12:00 PM, there was a portable space heater present on the bathroom sink counter in resident #5's bathroom.

Plan of Correction ***Directed (- 05/06/2025)***

On 3/31/25 the space heater immediately removed from resident #5's bathroom and properly discarded. A

127a - Portable Space Heaters (continued)

complete audit was done to ensure no other space heaters were present on 3/31/25 by unit coordinator. Education to all current staff was provided on 4/9/25 that no portable heaters are permitted in Personal Care. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). ED or designee will complete random audits of resident rooms to ensure space heaters are not in use. The audit will consist of 5 residents per week x 4 weeks, starting 4/28/2025, then monthly. Audit results will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25).

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/01/2025)

132d - Evacuation

8. 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 operates another licensed personal care home on the same campus. The following fire drill records for the home includes the resident census for both licensed facilities; however, the fire drills are not conducted at the same time. Also, according to numerous staff persons, the home does not conduct a head count of the number of residents that evacuated during each fire drill, so it is unable to be determined if all residents evacuated 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 during each of the following fire drills:

- *3/25/25 at 11:10 AM, which indicates 144 residents were present and 144 residents evacuated*
- *2/26/25 at 4:05 PM, which indicates 141 residents were present and 141 residents evacuated*
- *1/25/25 at 7:13 AM, which indicates 143 residents were present and 143 residents evacuated*
- *12/11/24 at 6:31 PM, which indicates 142 residents were present and 142 residents evacuated*
- *11/15/24 at 1:52 PM, which indicates 146 residents were present and 146 residents evacuated*
- *10/24/24 at 2:18 PM, which indicates 146 residents were present and 146 residents evacuated*
- *9/23/24 at 11:00 AM, which indicates 143 residents were present and 143 residents evacuated*
- *8/20/24 at 5:50 AM, which indicates 139 residents were present and 139 residents evacuated*
- *7/9/24 at 4:15 PM, which indicates 139 residents were present and 139 residents evacuated*
- *6/30/24 at 4:00, which indicates 132 residents were present and 132 residents evacuated*
- *5/20/24 at 1:00 PM, which indicates 136 residents were present and 136 residents evacuated*
- *4/8/24 at 2:00 AM, which indicates 136 residents were present and 136 residents evacuated*

On 3/13/24, documentation from a fire safety expert indicated the maximum evacuation time to evacuate residents to the home's fire-safe areas is 5 minutes, 51.03 seconds; however, the evacuation time for the fire drill held on 6/30/24 at 4:00 was conducted in 6 minutes, 25 seconds.

REPEAT VIOLATION: 7/27/2023, et. al.

132d - Evacuation *(continued)*

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

Unable to retroactively correct the accurate head count or accurate evacuation time. Residents at town hall to be educated on 5/6/25 on fire evacuation and time by the Executive Director or designee. all current Staff educated on fire drill evacuations, head count in safe zones by medication techs and announced over walkie-talkies and the timing on 4/9/25 by the Executive Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). Reviewed fire drill results with staff regarding evacuation time. Weekly fire drills to start week of 4/28/25 x4, then monthly to be conducted by Assistand Maintenance Director or designee, results will be reviewed by the Executive Director. (DIRECTED: Documentation of all fire drills shall be kept in accordance with 2600.132c. [redacted] 5/6/25). The fire expert was onsite in October 2024 with new evacuation time, the community has maintained compliance. results will be reviewed in quality management meeting on 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25).

DIRECTED: Beginning on 5/8/25: The administrator shall review all fire drill records monthly to ensure compliance with 2600.132a through 2600.132j, which includes ensuring the accurate census for the home is documented on the home's fire drill records and to ensure all residents physically evacuated 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 the monthly audits shall be kept for 6 months. [redacted] 5/6/25

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/01/2025)

132e - Fire Drill Sleeping Hours

9. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

According to the home's fire drill records, the most recent fire drill held during sleeping hours was conducted on 8/20/24 at 5:50 AM.

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

No residents were adversely affected. Assistant Maintenance Director and all current staff educated regarding fire drills during sleeping hours (2600.132.e)on 4/9/25. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). Compliance will be monitored by DHS fire drill record, fire drill will be keep in accordance with 2600.123.c. The fire drill outcome will be monitored monthly by ED or designee. A sleeping hours fire drill will be held during the week of 5/5/25. (DIRECTED: Documentation of the fire drill conducted during sleeping hours shall be kept in accordance with 2600.132c. [redacted] 5/6/25). Record to be reviewed at quality managment meeting on 5/28/25 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25).

132e - Fire Drill Sleeping Hours (continued)

DIRECTED: Beginning on 5/8/25: The administrator shall review all fire drill records monthly to ensure compliance with 2600.132a through 2600.132j, which includes ensuring an unannounced fire drill is held during sleeping hours at least once every 6 months. Documentation of the monthly audits shall be kept for 6 months. [redacted] 5/6/25

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/01/2025)

141b1 - Annual Medical Evaluation

10. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent medical evaluation, dated [redacted], does not include an assessment of resident #3's special health or dietary needs. This section of the medical evaluation is blank.

Resident #7's most recent medical evaluation, dated [redacted], does not include an assessment of resident #7's special health or dietary needs. This section of the medical evaluation is blank.

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

Residents #3 and #7 annual medical evaluation was corrected immediately with MD recommendations by Wellness Director. Audit completed on all current resident to ensure compliance with special health and dietary needs within the DME were completed on 4/30/25. Wellness Director and Nurses educated on the completion of the annual medical evaluation by the Executive Director on 3/31/25. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). New admissions medical evaluations will be audited weekly X4 weeks for the completion of special health and dietary needs, starting 4/28/2025. (DIRECTED: Beginning on 5/10/25: The administrator/designee shall audit at least 5 different resident medical evaluations monthly to ensure timely and complete medical evaluations are completed at least annually in accordance with 2600.141b. [redacted] 5/6/25). Audit to be completed by ED or designee. Audit results will be reviewed at the quality management meeting on 5/28/25 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25)

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/01/2025)

185a - Implement Storage Procedures

11. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #7 is prescribed Pregabalin 50mg capsule-Take 1 capsule by mouth once daily. On 4/1/25, the controlled substance record indicated 18 capsules were present; however, 19 capsules were present in the medication card.

Plan of Correction ***Directed (- 05/06/2025)***

on 3/31/25 the medication was signed out with the intent to administer. further investigation by Wellness Director on 3/31/25 indicates that the medication was adminitered during the appropriate time frame. Education provided to the medication tech on 3/31/25 by the Wellness Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Education consisted of signing out medication and pour/pass medication timely. A reconciliation of all med carts were completed with no other medication issues. Licensed nurses and medication techs were educated on 4/9/25 regarding safe storage, access, and distribution of medications. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Weekly audits of controlled substance sheets on all residents prescribed narcotics to ensure medications are signed out and administered per the MAR. Audits to be completed by the Wellness Director or designee weekly x 4 starting on 4/28/25, then monthly. Audits will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25).

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #3's March 2025 medication administration record (MAR) does not include a diagnosis or purpose for numerous medications, to include the following:

- *Atenolol-25mg tablet*
- *Duloxetine-60mg capsule*
- *Levothyroxine-88mcg tablet*
- *Nifedipine ER-90mg tablet*
- *Rosuvastatin Calcium-20mg tablet*

Resident #5's March 2025 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- *Entresto-24mg/26mg tablet*
- *Escitalopram-10mg tablet*
- *Furosemide-20mg tablet*
- *Omeprazole-20mg capsule*
- *Probiotic-250mg capsule*

187a - Medication Record (continued)

Resident #7's March 2025 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- *Atorvastatin-20mg tablet*
- *Nitrofurantoin MCR-50mg capsule*
- *Pregabalin-50mg capsule*

Resident #8's March 2025 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- *Vitamin D3-1,000IU (25 mcg)*
- *Xarelto-20mg tablet*
- *Bisacodyl-10 mg suppository*

Resident #9's March 2025 MAR does not include a diagnosis or purpose for Metoclopramide-5mg tablet.

Plan of Correction ***Directed (- 05/06/2025)***

Medications reviewed with the physician for resident's #3, #5, #7, #8, #9 and proper diagnosis was obtained on 4/1/25 by Wellness Director. Audit completed on 4/30/25 on all current residents to ensure all diagnosis are present in relation to prescribed medications. Wellness Director and licensed nurses educated on ensuring all admissions and new orders have a diagnosis for every medication on 4/9/25. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). Wellness Director or designee will audit new orders 5 days a week for proper diagnosis begining 4/28/25 x 4 weeks, then monthly. (DIRECTED: Beginning on 5/9/25: The administrator/designee shall audit at least 5 resident MAR's per week for 1 month, then monthly thereafter, to ensure each resident has an accurate and complete MAR in accordance with 2600.187a, which includes a diagnosis or purpose for each medication. 5/6/25). Audit results will be reviewed at the quality management meeting 5/28/25 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25).

DIRECTED: By 5/25/25: The administrator/designee shall educate all current staff persons qualified to administer medications on the home's medication administration procedures, which includes ensuring each resident has an accurate and complete MAR that includes all items specified in 2600.187a. Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25).

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

224a - Preadmission Screen Form

13. 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.

224a - Preadmission Screen Form *(continued)*

Description of Violation

Resident #2's preadmission screening form, dated [redacted] does not include a determination that the home can meet resident #2's needs. This section of the preadmission screening is blank.

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

Resident #2 preadmission screen was reviewed by Wellness Director with the physician and it was determined that the home can meet this resident's needs. (DIRECTED: By 5/9/25: The administrator shall update resident #2's preadmission screening to indicate the home can meet the resident's needs. The update shall include the date of the update and the administrator's initials. The updated preadmission screening shall be kept in resident #2's record. [redacted] 5/6/25). Audit of current residents completed on 4/30/25 to ensure preadmission screening form includes the determination that the home can meet the resident's needs. Wellness Director educated 4/9/25 on ensuring the determination is made that the home can meet the resident's needs. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). Executive Director or designee to audit all admissions for preadmission screening to include the determination that the home can meet residents needs, Audits starting on 4/28/25 x 4 weeks, then monthly. (DIRECTED: The audits shall begin on 5/10/25. 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25).

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/01/2025)

225a - Assessment 15 Days

14. 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 #2's assessment, dated [redacted], does not include an assessment of resident #2's ambulation needs. This section of resident #2's assessment is blank. Resident #2 currently uses a wheelchair. Also, resident #2's medical evaluation, dated [redacted] includes diagnoses of urinary tract infection, altered mental status and pyuria; however, these diagnoses are not indicated on resident #2's assessment, dated [redacted]

REPEAT VIOLATION: 7/27/2023, et. al.

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

Resident #2 RASP updated to accurately reflect the residents needs. On 4/28/25, the Executive Director educated Wellness Director on the accuracy of the written initial assessment, DME and Prescreen. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). Audit of new admission RASP's to be completed to ensure accuracy by the Wellness Director or designee. Audits will be completed weekly x 4 weeks then monthly. (DIRECTED: The audits shall begin on 5/10/25. [redacted] 5/6/25). Results of the audits will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25).

Proposed Overall Completion Date: 05/23/2025

225a - Assessment 15 Days *(continued)*

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

225c - Additional Assessment

15. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #4's most recent medical evaluation, dated , includes a diagnosis of Insomnia; however, this diagnosis is not indicated on resident #4's most recent assessment, dated

REPEAT VIOLATION: 7/27/2023, et. al.

Plan of Correction ***Directed (- 05/06/2025)***

resident #4 was examed by CRNP and no longer has a dx of insomnia, new DME completed to correlate with the RASP 4/30/25. Education to Wellness Director by the Executive Director regarding ensuring all DX are current and applicable. (DIRECTED: By 5/20/25: All staff persons responsible for completing resident assessments shall be educated by the administrator on ensuring resident assessments/support plans accurately reflect the residents' current needs. Documentation of the staff education shall be kept in accordance with 2600.65i. 5/6/25). All new admissions starting 4/28/25, along with annual assessments will be audited when completed to ensure the accuracy and current diagnosis. (DIRECTED: The audits shall be conducted within 48 hours of completion of the resident assessments. 5/6/25). Audits will be completed by the Executive Director or designee. Audit results will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 5/6/25)

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *05/28/2025*

Implemented (- 07/01/2025)

227d - Support Plan Medical/Dental

16. 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 #3 currently uses a bed enabler for turning/positioning; however, the bed enabler use is not indicated on resident #3's most recent support plan, dated

227d - Support Plan Medical/Dental (continued)

Resident #5 currently uses a bed enabler for turning/positioning; however, the bed enabler use is not indicated on resident #5's most recent support plan, dated [redacted]

Plan of Correction ***Directed ([redacted] - 05/06/2025)***

Residents #3 and #5 support plan were corrected immediately. Current residents audited for support plan accuracy on 4/1/25, no other residents affected. Wellness Director educated on 4/9/25 on the accuracy of the support plan by the Executive Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 5/6/25). Audit to be completed to ensure accuracy the service plan. (DIRECTED: By 6/1/25: The administrator/designee shall review the support plans for at least 50% of the residents currently residing in the home to ensure each resident has an accurate and complete support plan present. [redacted] 5/6/25). Audits to be completed weekly x 4 weeks, then monthly by the Executive Director or designee. (DIRECTED: The audits shall begin on 5/10/25 and shall include a review of at least 5 different resident support plans during each audit to ensure accuracy and completeness in accordance with 2600.227d. [redacted] 5/6/25). Audits will be reviewed at the quality management meeting 5/28/25. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 5/6/25)

Proposed Overall Completion Date: 05/23/2025

Directed Completion Date: *06/01/2025*

Implemented ([redacted] - 07/01/2025)