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

June 4, 2025

[redacted] ADMINISTRATOR
P.A.L., INC.
122 RIDGEVIEW STREET
YOUNGWOOD, PA, 15697

RE: RIDGEVIEW RESIDENTIAL CARE
122 RIDGEVIEW STREET
YOUNGWOOD, PA, 15697
LICENSE/COC#: 42858

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *RIDGEVIEW RESIDENTIAL CARE* **License #**: *42858* **License Expiration**: *11/06/2025*

Address: *122 RIDGEVIEW STREET, YOUNGWOOD, PA 15697*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *P.A.L., INC.*

Address: *122 RIDGEVIEW STREET, YOUNGWOOD, PA, 15697*

Phone: *7249250212* **Email**: *Ridgeview@rescare,comcastbiz.net; Mistydeaner@gmail.com*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/18/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *31* **Waking Staff**: *23*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/01/2025*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *31*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

04/01/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/25/2025*

04/25/2025 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/02/2025*

Inspections / Reviews *(continued)*

05/05/2025 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/31/2025*

06/04/2025 - Document Submission

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

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Approximately two weeks ago police officers from an unknown precinct arrived at the home to investigate an unspecified complaint made by resident #1 However, The home failed to notify the department.

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

On April 1, 2025, facility administrator faxed DHS a report regarding visit from state police approximately 2 weeks prior as part of this plan of correction. On April 3, 2025, facility administrator faxed DHS the report for a new police response call regarding the same named resident, as part of the plan of correction. Facility will continue notifying DHS for ALL emergency vehicle response calls, excluding ambulance responses, for all future events.

Immediate action: The inspector reminded me that I should have reported emergency vehicle responses (exception of ambulance) immediately to the state. Administrator faxed incident report to DHS on April 1 for 2-week prior police visit.

corrective action: Administrator faxed DHS on April 3 for police showing up that day. Administrator or Asst Administrator will fax DHS within 24 hours of any emergency vehicle being called to facility premises.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator shall review all reportable incidents and conditions weekly to ensure required reporting in accordance with Regulation 2600.16(c).

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

65a - FS Orientation 1st Day

2. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff member A, with date of hire [redacted] did not complete the initial Orientation training.

Staff member B: with a date of hire of [redacted], did not complete the initial Orientation training.

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

Staff member A completed initial training on [redacted] documents attached.

Staff member B completed initial training on [redacted] documents attached. However, [redacted] did not have fire safety sign-off in [redacted] file; this has since been completed and attached.

Moving forward, all staff will complete new hire and annual trainings when due.

65a - FS Orientation 1st Day (continued)

Immediate action: The inspector found incomplete training file for 2 staff. Asst Administrator and administrator reviewed the files and found trainings completed in a separate file folder.

corrective action: Administrator or Asst Administrator will complete a double check audit of all employee files.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall review employee training files monthly to ensure required training in accordance with Regulation 2600.65a.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff Member A, date of hire [redacted], did not complete training on resident rights within their completing 40 working hours.

Staff Member B, date of hire of [redacted], did not complete the initial Orientation training did not complete training on resident rights within their completing 40 working hours.

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

Staff Member A, date of hire [redacted] completed the resident rights training on [redacted]; the documents were located in her employee new hire folder. Copy attached.

Staff Member B, date of hire [redacted], completed the resident rights training on [redacted] the documents were located in her employee new hire folder. Copy attached.

Immediate action: The inspector found incomplete training file for 2 staff. Asst Administrator and administrator reviewed the files and found trainings completed in a separate file folder.

corrective action: Administrator or Asst Administrator will complete a double check audit of all employee files, both new employees & old employees.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall review employee training files monthly to ensure required training in accordance with Regulation 2600.65b.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

81b - Resident Personal Equipment

4. 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

At approximately 12:08 p.m., the bedside enabler on left side of resident #1's bed was able to be moved approximately 4 inches to the left and 4 inches to the right from center allowing for an aggregate range of motion of 8 inches. The bedside enabler had a space measuring approximately 12 x 6 inches in size in the top portion of the enabler's design.

At approximately 11:09 a.m., there was a bedside enabler on the left side of resident #2's bed. The enabler had an opening of approximately 12 x 8 inches in size. The bedside enabler was not secured properly to resident #2's bed allowing for the enable to be moved 6 inches away from and 6 inches towards the resident's bed.

At approximately 11:30 p.m., there was a bed side enabler on the left side of resident #3's bed. The bedside enabler had two separate spaces in its design, one on its far-left and one on its far-right, both spaces were each approximately 4 x 10 inches in size.

Repeat Violation 2/23/2024

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

Resident 1 discharged from this facility. Bedside enabler was removed.

Resident 2 bedside enabler was replaced with an enabler that has a cover. Bedside enabler was tightened and secured to bed.

Resident 3 bedside enabler was covered with appropriate enabler cover. Picture attached.

Administrator and Assistant Administrator will check/monitor bed enablers to ensure they are secure weekly x 4 weeks. Any resident requesting a bedside enabler, moving forward, will be required to have an appropriate cover over the enabler.

Immediate action: The inspector found insecure bedside enablers & bedside enablers that did not have an appropriate cover. Asst Administrator and administrator documented beds needing appropriate cover or secured tightly to bed. Admin and asst admin got covers on all aforementioned bedside enablers, covered them, and ensured all bedside enablers were secured to bed properly.

corrective action: Administrator or Asst Administrator completed a double check audit of all beds to ensure enablers are properly attached and covered for safety of all residents.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall audit all bedside enablers weekly to ensure compliance in accordance with Regulation 2600.81b.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11:26 a.m., there was an uncovered, unattended, black, plastic, 40-gallon garbage can approximately 7/8 full, immediately next to the food serving counter located in the home's main kitchen.

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

Trash can shall remain covered with impenetrable lid. Administrator and assistant administrator will monitor daily. Regulation reviewed with charge techs, who will continue to monitor daily.
Trash can lid was secured to trash can with zip tie.

Immediate action: The inspector found kitchen trash can was not covered with impenetrable lid. Asst Administrator and administrator covered trash can with lid.

corrective action: Administrator and Asst Administrator attached trash can lid with zip-tie to ensure lid remains attached to can for ease of covering trash.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator, asst admin or designee shall audit all trash cans weekly to ensure compliance in accordance with Regulation 2600.85d.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented (- 06/04/2025)

95 - Furniture and Equipment

6. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The kitchen cabinet door located in the lower level's kitchenette was broken, exposing a potential skin tear hazard.

At approximately 11:40 a.m., the fire door located immediately next to exit #6, did not close properly leaving an exposed gap in coverage approximately 1.5 inches wide along the entire length of the door.

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

On Saturday, April 5, 2025, the cabinet was repaired by maintenance. In the future, administrator and assistant administrator will repair any broken cabinets immediately.

Immediate action: The inspector found a broken cabinet in downstairs kitchen. Asst Admin removed the partial cabinet door so it could be repaired.

corrective action: Asst Admin had the cabinet door repaired and it was put back on the cabinet in question.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or designee shall audit the home and furniture weekly to ensure compliance in accordance with Regulation 2600.95.

95 - Furniture and Equipment *(continued)*

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

105g - Lint Removal and Duct Cleaning

7. 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 11:48 a.m., there was a golf ball sized accumulation of lint in the middle dryer located in the basement level laundry room. There was no clothing in the dryer.

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

Lint trap shall remain cleaned after each load of laundry. Administrator and assistant administrator will monitor daily. Regulation reviewed with charge techs, who will continue to monitor daily.

Signs posted for staff as a reminder to clean lint trap after each load.
Administrator and Assistant Administrator will check/monitor lint traps to ensure they are empty weekly x 4 weeks.

Immediate action: The inspector found golf ball sized lint in 1 dryer. Asst Administrator and administrator checked all dryers for lint & documented regulation for all staff to be educated on regarding lint removal.

corrective action: Administrator, Asst Administrator or designee will complete a double check audit daily of all dryer traps to ensure lint is removed immediately. Staff educated on process for lint removal.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall audit all dryer traps daily to ensure compliance in accordance with Regulation 2600.105g.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

132g - Fire Drills Days/Times

8. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills during sleeping hours at similar times as evidenced by the following drills held on/at. 1/25/24, at 6:00 a.m., 7/26/24, at 5:39 a.m., and 1/23/25, at 5:30 a.m.

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

Fire drill importance at different times has been discussed with staff.

132g - Fire Drills Days/Times (continued)

Nighttime fire drill will be performed on night shift at different times that are not close to the time that residents will be waking up.

Nighttime fire drills will be done every 6 months as required at different times throughout the night moving forward.

Immediate action: The inspector found facility was holding nighttime fire drills at similar times. Asst Administrator and administrator ensured inspector that home will hold fire drills at different times during sleeping hours.

corrective action: Administrator or Asst Administrator scheduled a fire drill for April 25 about 1:30 AM.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall schedule fire drills at different times to ensure compliance in accordance with Regulation 2600.132g.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

141a 1-10 Medical Evaluation Information

9. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's initial Documented Medical Evaluation was completed on [redacted] However, a height assessment was not completed. The field was blank.

Repeat Violation 2/23/2024

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

Resident 1 DME was corrected and signed by physician. Administrator and assistant administrator will both review DME to ensure completion and correctness with a double check system for all DME moving forward. Both will initial DME to signify review.

Immediate action: The inspector found resident DME was missing the height. Asst Administrator added the height to the DME for physician to sign off.

141a 1-10 Medical Evaluation Information (continued)

corrective action: Administrator or Asst Administrator will complete a double check audit (and initial) of all DME forms to ensure all fields are completed.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall audit & initial all DME forms monthly and each new resident to ensure compliance in accordance with Regulation 2600.141a.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented ([redacted] - 06/04/2025)

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 Documented Medical Evaluation was completed on [redacted].

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

Resident 3 DME completed for status change and signed by practitioner. All resident DME audited for correctness. Administrator and assistant administrator to complete DME annually and have practitioner review & sign. DME will be double checked by Admin & Asst Admin.

Immediate action: The inspector found resident DME was not updated for the annual evaluation. Asst Administrator reviewed with practitioner of need for status change DME.

corrective action: Administrator or Asst Administrator will complete a double check audit of all DME forms to ensure all fields are completed & initial after reviewed. Designee will also complete DME immediately when status change occurs and will have doctor sign DME.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall audit all DME forms monthly, new residents and status change residents to ensure compliance in accordance with Regulation 2600.141b1.

Licensee's Proposed Overall Completion Date: *05/30/2026*

Implemented ([redacted] - 06/04/2025)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 was prescribed insulin Lispro 100 unit 4 / ML pen inject sub-Q per SS with meals at bedtime 120 - 150 =

184a - Resident's Meds Labeled (continued)

0U, 151 - 180 = 2U, 181 - 200 = 4U, 201 - 250 = 3U, 251 - 300 = 8U, 301 – 350= 10U, 351 - 400 = 12U, 4O1 - 450 = 14U, 451 - 500 = 16U, greater than 500 call MD. However, the medication's label indicated, Lispro 100 unit 4 / ML pen inject sub-Q per SS with meals at bedtime 120 - 150 = 0U, 151 - 180 = 1U, 181 - 200 = 2U, 201 - 250 = 6U, 251 - 300 = 8U, 301 – 350= 10U, 351 - 400 = 12U, 4O1 - 450 = 14U, 451 - 500 = 16U, greater than 500, call MD

Resident #2 was prescribed NAC 600 mg capsule take my mouth one capsule twice daily. However, the medication label indicated NAC 1000 mg per capsule.

Resident #5 was prescribed coconut oil soft gels take one soft gel by mouth daily. However, the medication label indicated coconut oil soft gels take two soft gels for best results, take one soft gel during the day and one soft gel in the evening.

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

On April 2, 2025, administrator and assistant administrator requested stickers from the pharmacy. Stickers put into use on 4/2/25 on all medications that have different instructions than label directions. Stickers will be applied to all medications with different instructions than label directions, moving forward.
Sticker applied to Resident 2 NAC & Resident 5 Coconut oil.

Immediate action: The inspector found medication instructions did not match from manufacture bottle to MAR instruction. Asst Administrator contacted pharmacy to get "directions change refer to MAR" stickers and placed on all aforementioned bottles.

corrective action: when families bring in OTC medications, Med Techs will put meds in a bin in Med Room for Administrator or Asst Administrator to complete a check of all new medications entering the facility; if directions are different, labels will be stuck on front of medications to refer to MAR.

preventative action: Within 5 calendar days of receipt of plan of correction: on a monthly basis during medication check-in from pharmacy, admin and asst admin will check instructions between label and MAR; stickers will be applied if instructions are different. The administrator or asst admin shall audit all medications vs instructions to MAR to ensure compliance in accordance with Regulation 2600.184a.

Licensee's Proposed Overall Completion Date: *05/30/2026*

Implemented ([redacted] - 06/04/2025)

185b - Medication Procedures

12. Requirements

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

185b - Medication Procedures *(continued)*

Description of Violation

Resident #3 was prescribed Lorazepam .5 mg tab take one tablet by mouth at bedtime. However, the home did not have a procedure/protocol in place for accounting for the controlled medication.

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

Resident 3 Lorazepam .5 now on narcotic count sheet. Administrator and asst administrator will ensure medication is counted on narcotic sheet moving forward. In the future, any medications from outsourced pharmacy will be accounted for on narcotic count sheet.

Immediate action: The inspector found controlled medication, provided by hospice, double-locked but no controlled count sheet; med was marked as bedtime dose but did not include dates to be administered.

corrective action: Asst Administrator added medications to narc lock box, including a controlled count sheet for Med techs to sign off count for each shift.

preventative action: Within 5 calendar days of receipt of plan of correction: the med techs will give all medication delivery forms to admin office; The administrator or asst admin shall audit narcotics daily or upon delivery, including hospice-provided narcs, to ensure compliance in accordance with Regulation 2600.185b.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 06/04/2025)

187c - Refusal of Medication

14. Requirements

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

Description of Violation

Resident #1 was prescribed Oseltamivir 75 mg capsule take one capsule by mouth two times daily for 5 days. The resident refused the administration of the medication on multiple dates to include 3/5/25, through 3/9/25, at 8:00 p.m. However, the home failed to notify the prescribing physician.

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

Physician provided an order for Resident 1 that staff do not need to notify physician until resident refuses x 4 days. Moving forward, all staff will be educated to notify administrator and asst administrator of all refusals so physician can be notified. If necessary, admin or asst admin will discuss recurrent refusals with physician.

Immediate action: The inspector found that medication refusal was not reported to the physician. Asst admin reached out to physician to get order to delay physician notification to 4 days due to resident's frequent refusals.

corrective action: Asst Administrator and administrator to notify physician of medication refusals immediately; med techs to make administration aware of all refusals. Admin and asst admin will get order from physician to delay notification of reporting if refusals are a daily (or more often) occurrence.

preventative action: Within 5 calendar days of receipt of plan of correction: the med techs will report all refusals to

187c - Refusal of Medication (continued)

admin office; The administrator or asst admin shall audit all MARs weekly and monthly for refusals to ensure compliance in accordance with Regulation 2600.187c.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented (- 06/04/2025)

224a - Preadmission Screen Form

15. Requirements

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

Description of Violation

Resident #2's preadmission screening form, dated , does not include a date of completion. The field was blank.

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

Resident 2 preadmission screening form completed and dated by administration. All resident preadmission screening forms were audited for correctness. Administrator and assistant administrator to complete preadmission screening forms and date properly. Preadmission screening forms will be double checked by Admin & Asst Admin moving forward and will be initialed after reviewed.

Immediate action: The inspector found resident preadmission screening did not include the date of completion. Asst admin completed the form correctly.

corrective action: Administrator or Asst Administrator will complete a double check audit of all preadmission screening forms to ensure all fields are completed & initial after reviewed.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall audit/double check and initial all preadmission screening forms for new residents to ensure compliance in accordance with Regulation 2600.224a.

Licensee's Proposed Overall Completion Date: *05/30/2026*

Implemented (- 06/04/2025)

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 #2's most recent assessment and support plan completed on did not indicate the use of a bedside enabler. However, on 4/1/25, there was a bedside enabler located on the left side of the resident's bed.

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

Resident 2 support plan updated to include bedside enabler. Moving forward, administrator and asst administrator

227d - Support Plan Medical/Dental (continued)

will add to all support plans with double check system for correctness.

Immediate action: The inspector found resident 2 did not have bedside enabler listed on support plan. Asst admin added bedside enabler to resident support plan; Administrator double-checked/reviewed and initialed RASP.

corrective action: Administrator or Asst Administrator will complete a double check audit of all RASP forms to ensure all fields are completed & initial after reviewed.

preventative action: Within 5 calendar days of receipt of plan of correction: The administrator or asst admin shall audit all RASP forms monthly, new residents and status change residents to ensure compliance in accordance with Regulation 2600.227d.

Licensee's Proposed Overall Completion Date: *05/30/2026*

Implemented ([redacted] - 06/04/2025)