pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

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

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

Located at **2405 KNOB HILL ROAD, YORK, PA 17403**
(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 **75**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **July 18, 2025** until **January 18, 2026**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **334981**

ISSUING OFFICER

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JULY 18, 2025

[redacted]
President
EC OPCO York LLC
[redacted]

RE: Celebration Villa of York
2405 Knob Hill Road
York PA 17403
Certificate #: 334981

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 10, 2025, April 14, 2025, and July 2, 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 #334980) dated June 9, 2025 to June 9, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from July 18, 2025 to January 18, 2026.

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.

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
183(b)	II	42	$5	210	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a FIRST 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 FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *CELEBRATION VILLA OF YORK* **License #**: *33498* **License Expiration**: *06/09/2025*

Address: *2405 KNOB HILL ROAD, YORK, PA 17403*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EC OPCO YORK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/16/2011* **Issued By**: *York Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *53* **Waking Staff**: *40*

Inspection Information

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

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

Inspection Dates and Department Representative

04/10/2025 - On-Site: [redacted]

04/14/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *38*

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**: *38*

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

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

04/10/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/11/2025*

05/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/22/2025*

05/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/10/2025*

07/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/06/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 2/23/25, resident #1 fell in [redacted] bedroom. The resident rang [redacted] call bell for staff assistance at 3:52 AM. Assistance was not provided until 6:26 AM and the resident was observed wearing clothes from the previous day which were soiled with urine and feces. Two of the staff members on shift were sleeping at the time of the incident and neglected to provide care and assistance. This incident was reported to the Department on 2/23/25 by staff member [redacted] the home's Executive Director; however, this incident was never reported to the local Area Agency on Aging.

On 12/16/24, an alleged incident of resident-to-resident physical abuse was reported to staff member B; however, this incident was never reported to the local Area Agency on Aging.

Plan of Correction ***Directed ([redacted] - 05/23/2025)***

Immediate: On 4/10/2025, Executive Director instructed all team members to call Executive Director via phone immediately pertaining to all incidents of abuse, hospitalizations, injuries, deaths and emergencies. On 4/18/2025, Executive Director faxed Act 70 in regard to incident involving Resident #1 to AAA York County and PA offices of aging.
Training: On 4/17/2025, a meeting was held with all team members in community and Executive Director provided education pertaining to neglect and abuse and immediate reporting. Executive Director re-educated all team members on Resident Rights on 4/17/2025. Neglect and abuse training be reviewed at monthly staff meetings for 6 months, after 6 months this will be reviewed biannually at staff meetings.
Ongoing: Beginning 4/17/2025, Executive Director or member of leadership will monitor daily to ensure neglect is not happening by completing resident interviews and all reports of neglect are immediately reported to AAA.

(Directed)
In addition to the above plan of correction:

- *Beginning no later than 5/28/25, the Administrator or designee will discuss any potential incidents or abuse with staff from the previous day and ensure alleged incidents were reported to the local Area Agency on Aging timely. This will occur daily.*
- *Documentation of resident and staff interviews, staff education and reportable incidents will be kept by the home and available for review by the Department.*

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/08/2025)

16c - Written Incident Report

2. 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).

16c - Written Incident Report *(continued)*

Description of Violation

On 3/7/25 around 6:00 AM, resident #2 fell in the lobby of the home. On 3/8/25, the resident was transported to the hospital due to reported pain in [redacted] arm where resident #2 was diagnosed [redacted]. The home did not report this incident to the Department.

Repeated Violation - 10/1/24

Plan of Correction ***Directed ([redacted] - 05/23/2025)***

Immediate: On 4/10/2025, Executive Director instructed all team members to call Executive Director via phone immediately for incidents of abuse, injuries, hospitalizations, deaths and emergency situations. On 4/14/2025, Executive Director sent a state reportable for the incident involving Resident #2 to DHS.
Training: On 4/11/2025, Operations Specialist educated Executive Director on Regulation 16c. During staff meeting on 4/17/2025, Executive Director educated all team members on Regulation 16c with documentation kept.
Ongoing: Beginning 4/11/2025, Executive Director or a member of leadership will be reviewed daily to ensure any state reportables are sent timely. All state reportables will be reviewed at monthly QA meeting beginning in May 2025. Documentation to be kept.

(Directed)
In addition to the above plan of correction:

- *Beginning no later than 5/28/25, the Administrator or designee will discuss any incidents with staff from the previous day and ensure incidents were reported to the Department timely. This will occur daily.*
- *Documentation of incident discussions, staff education and incidents submitted to the Department will be kept by the home and available for review.*

Directed Completion Date: *05/28/2025*

Implemented ([redacted] - 07/08/2025)

17 - Record Confidentiality

3. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 4/10/25 at 9:15 AM, resident records for resident's #3, #4, and #5 were observed unlocked, unattended and accessible in the home's mail room. Accessible resident records included medical evaluations, assessment and support plans, resident demographic information and contracts.

Plan of Correction ***Accept ([redacted] - 05/23/2025)***

Immediate: On 4/10/2025 day of inspection, the Executive Director immediately locked the cabinets and pulled the door shut to secure all records. On 4/11/2025, a sign was placed on the door requesting that the door remain locked at all times.
Training: On 4/15/2025, the Executive Director educated the leadership team was on Regulation 17.
Ongoing: Beginning 4/11/2025, a member of management will walk the community daily to ensure that resident

17 - Record Confidentiality (continued)

records remain confidential and secured.

Licensee's Proposed Overall Completion Date: *05/23/2025*

Not Implemented (- 07/08/2025)

42b - Abuse

4. Requirements

2600.
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

On 12/16/24, resident #6 smacked resident #2 with hand across resident #2's face. Resident #2 was assessed and observed to have a red mark on the right side of face following the incident.

Staff members C and D have observed resident #6 in resident #2's bedroom on several occasions making inappropriate comments around resident #2. On one occasion when resident #2 was screaming, resident #6 was close by and stated, "oh just smack likes that." Staff members also indicated that resident #2 would "flip" if a would come up on TV. Resident #2 would say hurt me but couldn't verbalize to explain further. Resident #2 did not want to sleep in bedroom and would say "the is coming in my room, the is coming, nobody is listening to me." Staff members B and C recalled resident #2 would not allow staff to touch the resident "down there" or clean them for incontinence care.

Staff members in the home also reported seeing resident #6 come out of resident #7's room multiple times in March 2025. On 3/16/25, Resident #7 communicated that a was in room and brushed hair. On 3/17/25, Resident #7 communicated that a was in room, kissed and rubbed belly. These incidents were reported to the home on 3/16/25, 3/17/25 and 3/18/25. Resident #7 confirmed they did not feel safe when this happened.

On 2/23/25, resident #1 had an unwitnessed fall in bedroom and activated the call bell at 3:52 AM requesting staff assistance. Staff did not respond until 6:26 AM. Resident #1 was observed to be soiled with urine and feces and still wearing clothes from the previous day. The two staff who had the paging device connected to the call bell were sleeping while on shift and failed to respond to the resident's call for help; staff were terminated as a result.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: Resident #6 was admitted to the hospital on and did not return. Official discharged from the community was due to requiring a secured neighborhood. On 2/23/2025, Staff Member E and Staff Member F were placed on suspension pending investigation. Staff member E and Staff Member F were terminated on due to the investigation being complete and allegations against both staff members were found to be true. The call bell system was verified to be in working order by the Maintenance Director and Dining Director on April 4, 2025.
Training: On 4/17/2025, a training was held with all team members in community and education was provided on regulation 42-B via the Executive Director. The Executive Director re-educated all team members on Resident Rights and immediate reporting. On 4/17/2025, Executive Director provided education to all team members about RASPs and care needs as well as call bell response times. At May's all staff meeting the Executive Director/Dementia

42b - Abuse (continued)

Practitioner will educate on Aggressive Behaviors. This will be completed by May 31st with documentation kept. Beginning 5/1/2025, Executive Director will educate team members in community on resident abuse at every monthly team meeting for the next 3 months and then quarterly thereafter in perpetuity. Executive Director retrained all staff on 4/17/2025 on answering call bells timely and how to reset the system.
Ongoing: Beginning the week of 5/19/2025 the Executive Director will interview 3 residents weekly for 4 weeks, and then 5 residents monthly for 2 months to ensure no abuse, neglect,
or mistreatment has occurred. This will be reviewed beginning May 2025 at QA with documentation kept.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 07/08/2025)

58a - Awake Staff 16 or More

5. Requirements

2600.
58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

On 2/23/25, 33 residents were present in the home. Staff members E and F were scheduled on duty but were asleep in the home's model rooms during several hours of their early morning shift. Staff members E and F were terminated as a result.

Plan of Correction ***Accept ([redacted] - 05/23/2025)***

Immediate: On 2/23/25, Staff Member E and Staff Member F were placed on suspension pending investigation for sleeping during shifts. On 2/23/25, Executive Director began conducting investigation. On [redacted] staff members E and F were both terminated from their positions after investigation was founded. On 4/11/2025, copies of Staff Member E and Staff Member F's termination documents were sent to DHS for review.
Training: On 4/17/2025, Executive Director provided education on Regulation 58A to all staff members.
Ongoing: Beginning 4/17/2025, a member of management will walk the community between shifts to ensure that on duty team members on duty are visible and awake. A member of the clinical leadership team will conduct random nightly checks to ensure all staff are awake and present ***(Directed) Each shift will be checked at least once daily-*** *[redacted] Documentation will be kept.*

Licensee's Proposed Overall Completion Date: *05/23/2025*

Implemented ([redacted] - 07/08/2025)

85a - Sanitary Conditions

6. Requirements

85a - Sanitary Conditions *(continued)*

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

Description of Violation

On 4/10/25 at 9:20 AM, an uncovered bowl of leftover food was observed sitting on the counter of the kitchenette in Blue Hall. The food inside the bowl was covered with a thick layer of white and blue-green mold.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: On 4/10/2025, the Dietary Director immediately disposed of the moldy dish of food found in the kitchenette.
Training: On 4/17/2025, Executive Director provided sanitation education on Regulation 85A.
Ongoing: Beginning 4/17/2025, the lead caregiver on each shift will round in the kitchenettes daily while completing walking rounds with previous shift to ensure that there is no outdated food. For three months, a daily sign off sheet will be used for each shift to ensure that walking rounds are being completed. If outdated food is found, they will dispose of it immediately.

Licensee's Proposed Overall Completion Date: *05/23/2025*

Implemented (- 07/08/2025)

183b - Meds and Syringes Locked

7. 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

On 4/10/25 at 10:41 AM, the following medicated creams and powders were unlocked, unattended, and accessible in resident #8's bedroom: 3 remedy treatment powders and 2 bottles of Clinic Protect Zinc cream. Resident #8 is not assessed to self-administer medications per the resident's medical evaluation, dated 9/27/24.

Repeated Violation - 11/5/24, 4/23/24, et al.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: On 4/10/2025, Executive Director immediately removed medications from resident #8's room. On 4/15/2025, Executive Director and Operations Specialist completed walking rounds into each resident room in the community and checked for medications in room.
Training: On 4/17/2025, during mandatory team meeting, Executive Director provided all team members education on reporting medications in rooms to leadership. CMTs were educated on ensuring all medications are being administered as ordered and no loose pills are located in the med carts.
Ongoing: Beginning 4/21/2025, Resident Care Coordinator and/or Director of Nursing will audit 10 rooms monthly for three months. Beginning 5/2025 all self medicators will have a monthly self medication screening including medication storage by a member of the leadership team ***(Directed)Monthly self-medication screenings will begin no later than 5/28/25-*** *Documentation to be kept.*

183b - Meds and Syringes Locked (continued)

Licensee's Proposed Overall Completion Date: *05/28/2025*

Not Implemented ([redacted] - 07/08/2025)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 4/10/25 at 3:40 PM, a round, white pill was observed in the bottom of the second drawer of B1 medication cart.

Plan of Correction ***Accept ([redacted] - 05/23/2025)***

Immediate: On 4/10/2025, Resident Care Coordinator removed loose medication from medication cart and disposed of it during inspection.
Training: Executive Director, who is a PA Train the Trainer, provided education on 4/17/2025 to all CMTs on Regulation 183E.
Ongoing: Beginning 4/17/2025, Resident Care Coordinator began to complete weekly medication cart audits and document on med cart audit form and turn into Executive Director and Director of Nursing. This audit includes cleanliness of medication cart.

Licensee's Proposed Overall Completion Date: *05/23/2025*

Not Implemented ([redacted] - 07/08/2025)

184a - Resident's Meds Labeled

9. 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

On 4/10/25 at 3:45 PM, the pharmacy label for resident #8's Senexon-s did not include the current instructions for administration. The pharmacy label provided instructions to administer the medication as needed. However, the

184a - Resident's Meds Labeled (continued)

physician's order was to administer the medication twice daily.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: On 4/10/2025, Resident Care Coordinator placed a change of direction sticker on resident #8's Senna order in question and the correct order added to the MAR. Resident Care Coordinator performed initial audits on all labeling of medications in medication carts on 4/14/2025, 4/15/2025 and 4/16/2025.
Training: Executive Director, who is a train the trainer, provided training to all CMTs at the mandatory meeting held 4/17/25, on Regulation 184A.
Ongoing: Beginning 4/17/2025, Resident Care Coordinator and/or Director of Nursing will complete weekly audits of all medication labels to ensure they are they are labelled properly.

Proposed Overall Completion Date: 06/10/2025

Licensee's Proposed Overall Completion Date: *05/23/2025*

Not Implemented (- 07/08/2025)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #8 is prescribed Ipratropium/Sol Albuterol, inhale every 4 hours as needed for shortness of breath. On 4/10/25, this medication was not available in the home.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: On 4/11/2025, Resident #8's Ipatropium/Albuterol was ordered from community pharmacy via certified med tech. The medication became available in the community on 4/12/2025. Resident Care Coordinator performed medication cart audits on 4/14/2025, 4/15/2025 and 4/16/2025 to ensure all ordered medications were in community.
Training: On 4/17/2025, Executive Director provided education on reordering of medications and documentation required for when a medication is not in the community at mandatory staff meeting. Executive Director also provided education on 4/17/2025 to Certified Med Techs pertaining to reporting medications not being in community.
Ongoing: Beginning 4/17/2025, Resident Care Coordinator and/or Director of Nursing began to complete weekly medication cart audits and document on med cart audit form and turn into Executive Director.

Licensee's Proposed Overall Completion Date: *05/23/2025*

Not Implemented (- 07/08/2025)

187b - Date/Time of Medication Admin.

11. Requirements

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

Description of Violation

Resident #6 was prescribed Memantine tab HCL 10MG, take 1 tablet by mouth twice daily. The resident's February 2025 Medication Administration Record indicates this medication was administered on 2/28/25 at 7:00 PM; however, this medication was not available in the home from 2/18/25 through 3/7/25.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: The staff member who inappropriately documented the medication administration on resident #6 was termed on
Training: On 4/17/2025, Executive Director provided Certified Med techs education on proper medication documentation, proper notification of physician if medication is not available, and timely reordering of medications.
Ongoing: Beginning 4/17/2025, weekly MAR audits will be completed by one of the clinical management teams to ensure proper documentation and that medications are available. Audits will be reviewed at monthly QA starting May 2025.

Licensee's Proposed Overall Completion Date: *05/23/2025*

Not Implemented (- 07/08/2025)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #6 was prescribed Memantine- take 1 tablet by mouth two times a day. However, this medication was not administered to resident #6 between 2/18/25 and 2/26/25, as the medication was not available in the home.

Resident #8 was prescribed Metoprolol Suc tablet 25mg ER- take ½ tablet by mouth once daily. However, this medication was not administered to resident #8 on 3/9/25 and 3/13/25, as the medication was not available in the home.

Resident #9 was prescribed compression stockings to wear daily. On 4/14/25, the resident's April 2025 Medication Administration Record indicated that the compression stockings were applied at 6:00 AM. However, resident #9 was not wearing compression stockings 10:30 AM and the resident indicated staff did not assist with the application that morning.

Repeated Violation - 4/23/24, et al.

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: On 4/10/2025 Resident #6's PCP was notified of the missed doses by the Executive Director. Resident #6 was out of the community as of and discharged
On 4/14/2025 Resident #8's PCP and hospice was notified of the missed doses by the Executive Director. On 4/15/2025, Executive Director ensured that resident # 8's medication was delivered and available.
On 4/14/2025 Resident #9's PCP was notified of the missed treatment. On 4/15/2025, Executive Director ensured that resident #9's ted stockings were located in resident room to place on resident as ordered and staff were

187d - Follow Prescriber's Orders (continued)

immediately educated on ted hose donning and doffing.
Training: On 4/17/25, the Executive Director re-educated all medication techs on administering medications and treatments per physician orders and proper documentation of administration. Medication Techs were re-educated on re-ordering of medications what to do if a medication is not in the community.
Ongoing: Starting 5/21/2025, Resident Care Coordinator and Director of Nursing will audit Resident's MARS three times a week with documentation kept. All current Certified Medication technicians will have an observation and MAR review completed by May 30, 2025 by the Train the Trainer. Observations and MAR reviews will be completed monthly for 2 months and then quarterly. Documentation to be kept.

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

Not Implemented (- 07/08/2025)

225a - Assessment 15 Days

13. Requirements

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

Description of Violation

An assessment was not completed for resident #1, who was admitted to the home on

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: Resident #1 was discharged on Executive Director and Operations Specialist completed a community wide audit on resident RASPs on 4/15/2025.
Training: On 4/17/2025, Executive Director and Regional Director of Clinical Services provided training to the Director of Nursing and Resident Care Coordinator on RASPs (annual and significant change as well as timelines) and to capture all residents' individual needs.
Ongoing: Beginning 4/11/2025, Executive Director will review all DMEs and RASPs within 72 hours of admission to ensure they are completed in their entirety.

Licensee's Proposed Overall Completion Date: *05/23/2025*

Not Implemented (- 07/08/2025)

225c - Additional Assessment

14. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's assessment, dated , indicates that the resident is independent with toileting and bowel management, and is able to change and clean self independently. However, resident #2 frequently refuses assistance with personal care, is observed wearing soiled clothing and has started to urinate on the floor. The resident's

225c - Additional Assessment (continued)

assessment was never updated to reflect these changes.

Resident #8 has had an open wound on [redacted] since at least February 2025. However, the resident's assessment, dated [redacted], was never updated to address the need for wound care and treatment.

Resident #10's assessment dated [redacted], indicates that the resident is independent with transfers and ambulation, and requires minimal physical or oral assistance to evacuate in an emergency. However, on 4/10/25, resident #10 required the assistance of two staff members while utilizing a walker for ambulation and to transfer between a standing and a seated position. The resident's assessment was never updated to reflect these changes.

Resident #11's assessment dated [redacted] indicated the resident is independent with eating and had no dietary needs. However, since 9/11/2024, resident #11 has had an order for ensure daily due to poor appetite and history of weight loss with a directive to obtain weights monthly. The resident's assessment was never updated to reflect these changes.

Plan of Correction ***Accept ([redacted] - 05/23/2025)***

Immediate: Resident #2 was discharged on [redacted] and unable to update RASP due to being discharged. Resident #8's RASP was updated on 4/11/25 to include wound care needs by the Executive Director. Resident #10's RASP was updated on 5/12/2025 to include mobility and transfer status. Resident #11's RASP was updated on 4/25/2025 to include nutritional needs. Audit of all current Resident RASPs will be completed by 6/10/2025 to ensure all RASPs reflect the current needs of the residents, by Clinical leadership team.
Training: Executive Director provided training on RASPs (annual and significant change), DMEs and mobility status as it relates to evacuations to all clinical team members at mandatory staff meeting on 4/17/2025.
Ongoing: Executive Director or a member of leadership will review all updated/new RASPs on a monthly basis to ensure all needs are being met. This will be reviewed at Monthly QA beginning May 2025. With documentation kept.

Licensee's Proposed Overall Completion Date: *06/10/2025*

Implemented ([redacted] - 07/08/2025)

227g -Support Plan Signatures

16. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 participated in the development of [redacted] support plan on [redacted] The resident did not sign the support plan, nor did the home make a notation regarding the resident's inability or refusal to sign.

Repeated Violation - 11/5/24

Plan of Correction ***Accept ([redacted] - 05/23/2025)***

Immediate: Resident #2 was discharged on [redacted] unable to obtain a signature. By 6/10/2025, Executive Director and Operations Specialist will complete an audit of all resident RASPs to ensure that signatures were included.
Training: On 4/11/2025, Operations Specialist provided education to Executive Director and RCC pertaining to the requirement of signatures on resident support plans as well as resident refusals to sign support plan.
Ongoing: Beginning 4/11/2025, Executive Director will review all RASPs for signatures within 72 hours of admission, prior to being added to resident charts in perpetuity.

Licensee's Proposed Overall Completion Date: *06/10/2025*

227g -Support Plan Signatures *(continued)*

Implemented (- 07/08/2025)

252 - Record Content

17. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
4. Language or means of communication spoken or used by the resident.
16. The resident's medical insurance information.

Description of Violation

Resident #6's record does not include resident's identifying marks, religion, race, primary language, nor insurance information.

Resident #7's record does not include resident's identifying marks

Plan of Correction ***Accept (- 05/23/2025)***

Immediate: On Resident #6 was discharged from the community. On 4/10/2025 Resdident #7's demographic sheet was updated with identifying marks. An audit of all demographic sheets will be completed by the Clinical Management team by 6/10/2025.
Training: On 4/11/2025, Operations Specialist provided education to Executive Director on 2600.252 pertaining to demographics for each resident.
Ongoing:Beginning 4/11/2025, Executive Director will review demographic information to each move in within 72 hours of admission.

Licensee's Proposed Overall Completion Date: *06/10/2025*

Implemented (- 07/08/2025)